Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens State
 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death ρ 2. Date of Death Month 20 1 Physician/ Charles William Kramer Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Regional medical Salisburu feninsula Center Wicomico Birthplace (State or Foreign Country) If Under 8. Date of Birth (Month, Day, Year) 1 Year If Under 24 Hrs. **Funeral** Days Months Hours Director 1 **X** M 2 □ F 18 8463 87 6/14/1924 MD Usual Residence of Deced or 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant. If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director X Yes 2 No MDWorcester Ocean City 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? Funeral USA 21842 615 Harbour Dr 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black White, etc. þ 1 Never Married 2 Married 1X Yes 2 □ No
If Yes, Give
Year or Dates. Navy Baltimore. Maryland 21215-0036 1 Yes 2 No Specify. Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ Coppers Company master machinist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Mary Shield Charles Kramer and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 125 Waltham St. Maynard, Mass. 01754 (daughter) Diane Kramer other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 🖁 Burial 2 🗆 Cremation 3 🗆 Removal from State Parkwood Cemetery 9/24/2011 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of uneral 22. Name and Address of Facility The Burbage Funeral Home rvice Licensee 108 William St. Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each lin he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Hea Congestive disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending abusing and Due to (or as a consequence of): resulting in death) Last Medical Certificate: To Be Completed by Physician/Medical Box 68760 If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy

5 ☐ Other (specify) ____ IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Year Yes 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 filled in by the funeral director, page 2 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 No 1 Yes Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D 63199 address of person who completed cause of death (Item 23a) (Type, Print) Salisbury Vohra 100 Camil ST esh 10+1 31. Date filed (Mont 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended 18 - State Registrar FH, TCHD, pha 9/12/11 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month ANNE MORTON KIMBERLY 9:20P M 09 2011 Medical 08 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death 26546 PRESQU'ILE DR. S. EASTON TALBOT Social Security Number If Under 1 Year If Under 24 Hrs Funeral 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign 1 - M 2 X F Months Days Hours Min. 05-20-1917 KENTUCKY Director 94 218-78-3808 : If item 27 is marked other than "natural", or items 23a or 28a-f shov or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 X No MD TALBOT 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 26546 PRESOU'ILE DR. S. 21601 UNITED STATES 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 X No 1 Tes 2 No Specify: Specify: 3 Widowed 4 Divorced Year or Dates. WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 2 should be filed w...
and Mental Hygiene.

**-d other than "p*

**-d other than "p* 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 NORRIS PRATHER WITTY SAUNDERS PAUL JONES II permit. Page 1 and 2 should Department of Health and M Important: If item 27 is man any injury or other traumat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANNE MORTON WYMAN DAUGHTER 11470 WYE HEIGHTS ROAD, EASTON, MD 21601 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 09-13-2011 WYE MILLS, MD 21. Signature of Funeral Service Licenses FELLOWS. HELFENBEIN & 200 S. HARRISON ST., NEWNAM FUNERAL HOME, P.A. EASTON, MD 21601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final allue Onset and Death Physician/ disease or condition Medical resulting in death) Examiner hemi 6 mer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of anding physician ause as the burial-Physician/Medical VC. Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year ☐ Yes 2 ☑ No ate has been signed by the a page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ - by llation Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Director: After this certificate 2 No Yes 1 Yes To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 🗌 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 Matural injury 5 Pending 2 Accident
3 Suicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 555 Cynwood Dr DO H Schille

Registrar
DHMH 17 Rev 7/2009

State

32. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Qlistu Certificate of Death TCND. Ph Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ANE 37 OSE Medical 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death County of Death **Examiner** 8. Date of Birth (Month, Day 9. Birthplace (State or Foreign Funeral m D Country) 1 M 2 F Director 28a-f show 10d. Inside City Limits 10c. City, Town or Location with the Maryland notified at Director 1 Ves 2 □ No 10f. Zip Code 10g. Citizen of What Country? ō must be n Funeral items? filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status er than "natural", or iter the Medical Examiner Armed Forces?

1 Yes 2 No Black, White, etc 1 Never Married 2 Married þ 1 🗆 Yes 2 No Maryland 21215-0036 Specify. If Yes, Give Specify: Black Completed 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Anne Arundel Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygene. Important: If item 27 is marked other tha any injury or other traumatic event, the Aones. Hygiene. Food Server Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Blooms Baltimore, Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place Burial 2 Cremation 3 Removal from State ambridge 4 Donation 5 Sther (Specify) Smi Home Cambridge MA21613 23a. Part 1. Enter the deease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between 2 JEPS15 Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, it also leading to immediate cause. Enter Underlying Examiner burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Hospital or Attending Physician; The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician Physician/Medical P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy signed by the atte in the past 12 months? Month Pregnant at time of death 5 Other (specify) g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, I Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? MANDRIN Hospital: Other: HUSPICE 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence HOU'SE 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1- Natural 5 \square Pending work?
1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 L 3 D only one) 29d, Date signed (Month, Day, Year) 29b. Signature and title of pertific 29c. License number 21438 u 30. Name and address of person who completed ause of death (Item 23a) (Type, Print) MICHAEL 31. Date filed (Month, Day, Year) Segistrar's Signatur State SEP 15 2011 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 32504 State of Maryland / Department of Health and Mental Hygien Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 1715 P^M 9 2011 Michael Edward Kern 3 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Salisbury
If Under 1 Year | IrUnder 24 Hrs. | 8. Date of Birth (Month, Day, Year) 31290 Old Ocean City Road Wicomico Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 12 M 2 ☐ F 7. Age (In yrs. last birthday) **Funeral** Days WV 6-28-1949 Director 229-<u>66-6212</u> Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Show ral', or Itema 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 No Salisbury MD Wicomico Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with I nent of Health and Mental Hygiene. sht: If item 27 is marked other then "netural, or Itema 23e or? USA 31290 Old Ocean City Road 21804 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No Army Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 966-68 1 ☐ Yes 🎾 No SpeciWhite 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 27 is marked other then "neture traumatic event, the Medical Elementary/Secondary (0-12) College (1-4or 5+) I.H. Construction 12 Carpenter 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Oscar D. Kern Clydear Gent 2 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mischelle Kern-Johnson/ 31290 Old Ocean City Rd, Salisbury, MD21804 20b. Place of Disposition (Name of Cometery, crematory or other place) 20c. Location - City or Town, State Date 20a, Method of Disposition permit. Pages 1 Department of h Importent: If ite 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (**Bocify) Direct Cremation, 9-19-2011 Dover, DE Bennie Smith 21. Sign tyre of Funeral de vice Licens Salisbury, MD 21801 Funeral Home Approximate Interval Between Onset and Death 23a. Part 1. Emerate disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospitel or Attending Physician: The law requires that the death certificate be executed physicien and is the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as the attending I for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 Dunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 2 D No 1 Yes 25. Was case referred medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 N Sidence 6 Other (Specify) 2 No 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA ၉ After thi 28d. Describe how injury occurred 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 1 Watural 5 Pending investigation To the mount after death.

To the Funerel Dire for: Aft 1 ☐ Yes 2 ☐ No M 2 Accident 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier TO

DHMH 17 Rev 1/2001

State Registrar 31. Date liled (Month, Day, Year)

NSIBEE DR

SALISBURY MD 21804

death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Mar	ryiand / Depa Cer	tificate of L			2011	32505			
	Physicia	ın/	Decedent's Name (First, Middle, Last		Lubrano			2. Date of Dea	er ^{Da} Ž7, 2Ö1	3. Time of Death			
,,,,,	Medic Examin	cal	Eaura Pug 4a. Facility Name (if not institution, give	<u></u>	Lubiano	4b. City, Town, or	Location of Death	Septemb	4c. County of Dea				
-	LAGIIIII		2885 Dunleigh D	rive		Du	ınkirk			lvert			
	Funeral Director		5. Social Security Number 219-27-3049 Usual Residence of Decedent	ex 7. Age (I	n yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	9. Bi	ounty) 1taly				
	show dat	lor	100 0 0										
	Mary 28a-f otifie	irec	MD Calvert Dunkirk							1 Yes 2 X No			
	vith the 23a or st be r	Funeral Director	10e. Street and Number 2885 Dunleigh	Drivo		10f. Zip Code)754		10g. Citizen of What CITaly	ountry?			
336	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at	Completed by Fune	11. Marital Status 1 Never Married 2 Married 3 W Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.			ispanic Origin? (Sp. n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify: V				
2-0	2 hours "natur edical	plete	15. Decedent's E (Specify only highest gr	ducation	16a. Deced	dent's Usual Occup	ation during most of work	rina	16b. Kind of Business	s Industry			
Maryland 21215-0036	should be filed within 73 and Mental Hygiene. is marked other than aumatic event, the Me	Com	Elementary/Seconday (0-12)	College (1-4 or 5+)	life. D	O NOT use retired) Deli Owne	_	9	Self Empl	Loyed			
d 2	filed within tal Hygiene. Ind other than event, the M	Be						ne (First, Middle, I	Maiden Surname)				
ylaı	should be file n and Mental H 7 is marked o raumatic eve	Jo	Raimondo	Rosa			orano						
	- O the L	-17	19a. Informant's Name/Relationship (7) Maria Lubrano (d			ng Address (Street a Dunleigl		al Route Number, Dunkirk	; City or Town, State, 2 , MD 20754				
Baltimore,			20a. Method of Disposition 1 X Burial 2 Cremation 3 4 Donation 5 Other (Specie	Removal from State	20b. Place of Dispo	sition (Name of natory or other plac	!	^{Date} Unk	Monte Di Naples. I	Procida			
Balti	permit. Page Department of Important: If any injury or once.	A	21. Signature o uneral Service Licens	off	22	2. Name and Address	ss of Facility Le hern Mary	ee Funera land Bl	al Home Cai	lvert, PA			
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death disease or condition Castric Cancer										
	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death) a. Gastric cancer Due to (or as a consequence of):										
	Examiner			Due to (or as a c	consequence or):								
	icate be executed physician and is the burial-transit	fedical Examiner	Sequentially list conditions, If any, leading to immediate Cause. Enter Underlying Due to (or as a consequence of):										
		Exar	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as a c	consequence of):								
90	e be e	lical	L L	d									
68760	rtificat ling ph e as th	/Mec	IF FEMALE:	On Hunn nutrame of									
Вох	the death certificate be executed by the attending physician and ached for use as the burial-transif	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at ti 9 Unknown	cy		23d. Date of o	lelivery Day Year					
ds, P.O.	requires that the de been signed by the should be detached	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause 1 Yes 2 No 3 Probably 4										
Division of Vital Records,	The law cate has page 2	Completed				24a. Was a autop perfor	autopsy findings available o completion of cause of ? /es 2 \(\sum \) No						
/ital	ysician: The is certificate director, pag	m	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	t 2 🗆 ER/Outpatier	Oth	er:						
on of \	nding Physath. r: After this e funeral di	icate: To	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day,)	28b. Time of	28c. Injur	y at	Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred					
	tal or Atten rs after deat al Director; ed in by the	l Certificate:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury building, etc. (- At home, farm, str Specify)	eet, factory, office			n (Street and Number or Rural Route Number, Town, State)				
	To the Hospital or Atten within 24 hours after deat To the Funeral Director. completed filled in by the	Medical	(Check 2 Medical Exam only one) 3 Certifying Nur	sician: To the best of miner: On the basis of example Practioner: To the be	mination and/or invest	tigation, in my opinion	on, death occurred a e time, date and pla	at the time, date a ace, and due to the	nd place, and due to the cause(s) and manner	e cause(s) and manner stated. as stated.			
	vit cor		29b. Signature and title of certifier	ZIOA		29c. Licenso	906 i		29d. Date signed (Mor	nth, Day, Year)			
4	RN 6		30. Name and address of person who a	completed cause of dear	th (Item 23a) (Type, F	Print) Suite 1	05, Prin	ice fre	derick	MD 20678			
Ì	Stat Registra		31. Date filed (Month, Day, Year)	32. Registra	s Signature	backer	,						

				For State Registrar			State	of Ma	ırylanı		epartme Certifica				/lental Hy	gien Reg. N	201		325	06			
		Physicia Medic		Decedent's Nam Jean Luc			7								2. Date of Do		16 20	ear	3. Time of D				
(Examir																					
		Funeral Director		5. Social Security N 578-24-1	umber	6. Sex	M 2 💢 F	7. Age	(In yrs. Ia		ay) If Un	der 1 Year		der 24 Hrs. rs Min.	8. Date of Bi (Month, D 5-9-1	rth ay, Year)	1 9	9. Birtho	lace (State or I ry) ngton I	Foreign			
		ind ihow at	'n	Usual Residence of 10a. State	Decedent 10b. County				10c. City	, Town o	r Location							10d. Inside City Limits					
		Maryla 28a-f s otified	Director	MD	Talbo	t			Ea	ston									1 🔀 Yes 2	2 □ No			
		with the 23a or st be n	eral D	10e. Street and Nur 700 Port		t #5	540				10f.	Zip Code 216	01			_	Citizen of Wh	at Coun	try?				
5	36	after death value al", or items	d by Funeral	11. Marital Status 1 Never Marr 3 Widowed	ied 2 🔀 Marr	12	2. Was Dec Armed For 1 Yes If Yes, Gi Year or D	orces? 2 X N					lispanic an, Mex		ecify Yes or No Rican, etc.)	-	14. Race - Black, Specify:	Americ White, 6	etc.				
Ca	2-00	2 hours "natura edical E	Completed		15. Deceder	nt's Educa st grade	ation			(G	ecedent's U Give kind of v	vork done	during n	nost of work	ing	16b.	Kind of Busi	ness Inc	lustry				
1, 7	21215-0036	within 7 giene. er than , the Me		Elementary/Second 12	onday (0-12)	2	College (1-4 or 5+	·)	Dea	e. DO NOT (.1er	use retired)				An	tique	Do1	ls				
usby,	Maryland	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be								18. Mother's Name (First, Middle, Ma Anne Howard Keyes												
T	aryl			19a. Informant's Na						19b. M	/lailing Addre	ess (Street			al Route Numb		or Town, Stat	te, Zip C	ode)	_			
	e, ⊠			Edward W. Lusby Jr. (Son)					Lagt. Di		9 Dai:		ne I	1	ook CA		·	04-4-					
	mor			20a. Method of Disposition 1 ☐ Burial 2 [X] Cremation 3 ☐ Removal from 5 4 ☐ Donation 5 ☐ Other (Specify)					Che	emetery, sape	crematory of ake C.	r other plac remat	ion		Date -2011		Location - C	•					
	Baltimore,			21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Hom 200 S. Harrison St. Easton MD 21601											. A.								
	Ħ		Н	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Shock, or heart failure. List only one cause on each line. Approximate Interval Between												een							
	14	nysician/ Medical		Immediate Cause (disease or condition resulting in death)	Final	a.	19	<u></u>			Cera	ebra	21	Vasa	cular	Ac	cide	NI	Onset and De	eath			
22		Examiner		Secuentially list no	acentoria.	Γ.	Due to	(or as a	consequ	ence of):													
		ed 1sit	Examiner	if any, leading to im cause. Enter Under Cause (Disease or	nmediate rlying		Due to	(or as a	consequ	ence of):													
		sate be executed physician and the burial-transit	al Exa	that initiated events resulting in death) I	s Last	C.	Due to	(or as a	consequ	ence of):								\top	-				
	100	icate be physic s the bu	ledical			d.																	
	. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 before death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 2 9 ☐ Unknown	months?	230	i. If yes, ou 1 Live 4 Preg 9 Unk	Birth 2 gnant at	☐ Fetal	death	3 Ectop 5 Other		су			- 59	23d. Date Monti		ery Day Ye	ar			
	s, P.O	iires that th signed by Id be deta	d by Pl	25e. Did tobacco use contributing to death but not resulting in the underlying cause given in Fact.																			
	Division of Vital Records, P.O.	he law requi ite has been age 2 should	Completed												24a. Was auto per 1 \subseteq Yes	opsy ormed?	pri de:	or to co ath?	osy findings av	railable use of			
	ta	certifica ector, I	Be (25. Was case referre	ed to medical	Hos	spital: 👡					Oth	er.	Death (Chec									
	n of V	iding Phys th. After this funeral dir	cate: To	1 ☐ Yes 2 2 27. Manner of Death 1 ☐ Natural 2 ☐ Accident	1 28a. Date	_		ER/Outpa 28b. Tim inju		28c. Injur	4 L y at </th <th>Nursing Ho</th> <th></th> <th colspan="3">5 Residence 6 Other (Specify) Describe how injury occurred</th> <th></th>	Nursing Ho		5 Residence 6 Other (Specify) Describe how injury occurred									
	Divisio	tal or Atter s after dea al Director ed in by the	I Certificate:	3 ☐ Suicide 4 ☐ Homicide	Investig 6	not be	28e. Place build	e of Injur ling, etc.	y - At hor (Specify)	me, farm	, street, fact	ory, office			28f. Location City or To			or Rural	Route Numbe	r,			
		the Hospil hin 24 hour the Funera npleted filla	Medical	(Check 2 only one) 3	ertifying Medical E Certifying	xaminer:	: On the ba	sis of exa	amination	and/or in	rvestigation, ge, death oc	in my opini curred at th	on, deat e time,	h occurred a date and pla	it the time, date	and pla he caus	ce, and due to e(s) and mann	othe ca ner as st	use(s) and mani ated.	ner stated.			
4		To Cor		29b. Signature and	title of certifier)	16) (2/	•	2	29c. Licens	e numb		2	29d. E	Date signed (7611			
		7		30. Name and address 219 South											nnis M.	Des			√ /6 ·	2011			
Da		Stat Registra	e ir	31. Date filed <i>(Montl</i>	EP 19	2011	32	Registrar	s Signatu	1. 1	back	1							· · ·				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year SEPTEMBER 17, 2011 Physician/ <u>6:</u>15 P ^M WILLIAM A. LARRIMORE Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** CAROLINE HOMESTEAD MANOR DENTON 9. Birthplace (State or Foreign Country)
MARYLAND Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Min. Days JULY 2, 1916 1 X M 2 □ F Hours Director 95 213-18-4903 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. It is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 ☐ Yes 2X No CAROLINE DENTON MD 10f. Zip Code 109. Citizen of What Country? 10e. Street and Number Funeral 410 COLONIAL DRIVE 21629 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 X Yes 2 If Yes, Give Black, White, etc. þ 1 Never Married 2 X Married 2 No 1 ☐ Yes 2 X No Specify: WHITE Specify. Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) **FARMER** AGRICULTURE 6 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 ROBERT RUSSELL LARRIMORE NELLIE USILTON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JEFFREY W. MUELLER, GRANDSON 30733 KINGSTON ROAD, EASTON, MD 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 Department of I Important; If it 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) injury or 9/22/2011 EASTON, MARYLAND SPRING HILL CEMETERY 2. Name and Address of Facility
ELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P
00 SOUTH HARRISON STREET, EASTON, MD 21601 21. Signature of Funeral Service Licensee any in 13 HN R. MERCERON 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final chronic renal failure Physician/ acute 00 Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to for as a consequence of: that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 4 Pregnant Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 🗌 Yes 2 🗆 No 1 ☐ Yes 2 [25. Was case referred to medical 26. Place of Death (Check only one) Be Assisted examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No Hospital: ဂ္ 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA JAIN 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No

Hospital or Attending Physician: The law requires that the death certificate be executed ng physician and as the burial-transit signed by the attending physician a be detached for use as the burial Division of Vital Records, P.O. Box 68760 in 24 hours after death.

the Funeral Director: After this certificate has been in pleted filled in by the funeral director, page 2 should

Baltimore, Maryland 21215-0036

Certificate:

Medical

29a. Certifier

(Check

only one)

1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation

6 Could not be determined

1 Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

00053255

Preston

29d. Date signed (Month, Day, Year) 1106

21622

28f, Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chaptank Rd 3683

B 31. Date filed (Month, Day, Year) **SEP 20**

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

State

Registrar

within 2 To the I

8+VA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death SEPTEMBER Physician/ Robert Wayne Lambert 735 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death MEMORIAL HOSPITAL TALBOT EASTON Ago (In yrs. last birthday) 5. Social Security Number 6. Sex 14 M 2 I F 8. Date of Birth (Month, Day, Year) 4-15-1954 9. Birthplace (State or Foreign Country) **De** • If Under 1 Year If Under 24 Hrs. **Funeral** Days 212-66-1634 Hours **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Talbot St. Michaels Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21663 214 A North Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Army Black White etc Specify: White Completed by 1 Never Married 2 Married 1 Yes 2 No Specify. 3 Widowed 4 XDivorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry **Home** (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Improvement House Painter Be 18. Mother's Name (First, Middle, Maiden Surname)
Sally J. Jones 17. Father's Name (First, Middle, Last) Lambert Avery 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 9734 Tilghman Island Rd. McDaniel, Md. 21647 Elizabeth T. Gowe/ Sister 20a. Method of Disperition
1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)

Crematory of Delmarva 20c. Location - City or Town, State 9-20-2011 Delmar, De. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Humley Ald Ostrowski Funeral Home P.A. Jaseph STRUSK. P.O. Box 518 St. Michaels, Md. 21663 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ INFECTIVE ENDUCARDITIS disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner ONGESTIVE PAILURE Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of INFARCTION ACUTE Hospital or Attending Physician: The law requires that the death certificate be executed MYOCARDIAL DAYS attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Month Year 1 Yes 2 No signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? è STENOSIS CRITICAL 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed AORTIC is certificate has been si director, page 2 should I SEVERE 24b. Were autopsy findings available prior to completion of cause of 24a. Was an COPD autopsy performed? death? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 1 Residence 6 \(\text{Other} \) Other (Specify) 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA မ within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

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ROBI

LAMBERT

State Registrar 31. Date filed (Month, Day, Year) **SEP 20 2011**

KOLLI

Francis MD

RAMESH

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



2195

WASHINGTON ST

D0066441

EASTON

SEPTEMBER 18 2011

21601

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day PM CHARLES Sept 2011 LAWRENCE MCNALLY Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Stella Maris Hospice Timonium Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs g. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days Hours Min (Month, Day, Year) 220-30-1641 Usual Residence of Decedent **Director** 1 💥 M 2 🗆 F 76 Marvland 28a-f show 10a. State 10b. County with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No MD. Harford Baldwin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2526 Greene Road 21013 United States 12. Was Decedent Ever in U.S. Armed Forces? 1952
1 X Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced 1995 Year or Dates Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me once. Elementary/Secondary (0-12) College (1-4 or 5+) Insurance Adjuster Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Charles A. McWally Lanasa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SEPTEMBER (Wife) Irene McMally Box Baldwin. 21013 Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Sept. 10. 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St Jo] Cem Lutheran Jacksonville, MD 22. Name and Address of Facility E.G. Kurtz & Son Funeral Jarrettsville. Maryland 23a. Part 1. Enter the disease, or complications that capsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sici. n disease or condition resulting in death) BILE DUCT CANCER Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed Gause (Disease or injury that initiated events resulting in death) Last pue Due to (or as a consequence of): attending physician a for use as the burial Physician/Medical of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ Live Birth 2 Fetal death in the past 12 months? Year Month Pregnant at time of death Day Yes 2 No been signed by the should be detached 9 Unknown CHARLES MCNALLY Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s perform this certificate Yes 2 X No 2 🗌 No 1 Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 🗌 Yes 2 X No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🗶 Other (Specify) HOSPICE funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred eral Director: After filled in by the funer 1 X Natural 5 Pending Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) hours after within 24 hours a

To the Funeral C

completely filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

DHMH 17 Rev 06-2011

29b. Signature and title

JACKIE JONES,

2300 DULANEY VALLEY RD.

person who completed cause of death (Item 23a) (Type, Print)

32. Registrar Signature

CRNP

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

TIMONIUM, MD 21093

X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle | 1 ast) 2. Date of Death 3. Time of Death September 20,2011 Physician/ PATRICIA SUDAN MUNDY \mathbf{P}^{M} 8:45 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Wilson Health Care Center Gaithersburg Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 M 2 T Months Days Hours Min March 17,1918 Country Georgia 93 252-09-6021 Director Usual Residence of Decedent Show 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at death with the Maryland Director Maryland | Montgomery Gaithersburg 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 419 Russell Ave. 20877 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Page 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or it any injury or other traumatic event. The Median Process. Black, White, etc. Completed by 1 Never Married 2 Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White If Yes. Give 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Artist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Emma Sue Lee Philip Paul Sudan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 54 Golden Ash Way Gaithersburg, MD 20878 Linda A. Mundy (Daughter) Date 21, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Alexandria, VA Metropolitan Crem. 2011 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service 22. Name and Address of Facility DeVol Funeral Home (M01116)10 East Deer Park Dr. Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between 10 Month and Beath Immediate Cause (Final Physician Cerebrovascular Accident disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner 1 Year Atrial Fibrillation Sequentially list conditions cause. Enter Underlying Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director. Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 1 ☐ Yes ∠ ¥ 9 ☐ Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 ☐ Yes 2 🙀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 10 1 🗆 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 🔀 Natural 5 Pendina 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 🗜 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only c 29d. Date signed (Month, Day, Year) 29c. License number Signatur nd title of certif September 21, 2011 D19294

DHMH 17 Rev 7/2009

State Registrar D_z

31. Date filed (Month, Day, Year)

911 Russell Ave. Gaithersburg, MD 20877

ddress of person who completed cause of death (Item 23a) (Type, Print)

John R. Melnick M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			For State Registrar	State of Mar	-		nt of H te of D		and M		Reg. No.	011	325	
	Physicia		1. Decedent's Name (First, Middle, La	,	1					Month Day Year			3. Time of	
-	Medic Examin		Walter Buckner Mitchell 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of						September 25 20 Death 4c. County of Death			4:	25₽ [™]	
1)		Berlin Nursing Home Berlin 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year I funder 24								rcest	er		
	Funeral Director		215-30-9633	Sex 1 ZKM 2 □ F	78 Yrs. Yrs.	If Und Months		If Under 2 Hours	Min.	8. Date of Birt 12-20		9. Birthp Count	ace (State o	_
	land show d at	or	Usual Residence of Decedent 10a. State 10b. County	10	0c. City, Town or Lo	cation						10	d. Inside Ci	ity Limits
	Maryla 28a-f s atified	rect	MD Worces	ter	Ocean C	ity							1 🗆 Yes	2 🙀 No
	th the 3a or 2	al Di	10e. Street and Number				ip Code	2			10g. Citizen	of What Count	ry?	
	ath wii	Funeral Director	209 10th Stree	12. Was Decedent Ever	r in U.S. 13. V		2184		in? (Spec	cify Yes or No-	14	USA Race - America	ın İndian.	
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 ☐ Never Married 2 【X Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?		f Yes, spe	ecify Cubar 2 X No	n, Mexican,	Puerto F	Rican, etc.)		Black, White, e		
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TER 21215-0036	thin 72 ine. than " ie Me	Completed	Elementary/Seconday (0-12)	College (1-4 or 5+)	life. D	O NOT us	se retired)	uring most	or workir	-	Tong	and F	05±01	_
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Man	shoul and I is ma		19a. Informant's Name/Relationship (Type, Print)		_						vn, State, Zip C		
E, P	and 2 Health tem 27		Sandra C. Mitc 20a. Method of Disposition		211 20b. Place of Dispo			tree		ot.2W		on - City or To		21842
MITCHE) Saltimore,	Page 1 lent of int: If ii		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	Removal from State	cemetery, crem First S	natory or	other place	em.	_	7-11		Lsboro		
MITCHEI Baltimore,	permit. I Departra Importa any inju		21. Signature of Funeral Service Licer	ase Lond	22	. Name a	and Addres	s of Facility	Bur	bage	Funer	al Ho	me 1	
			23a. art . Enter the disease, or cor shook, or heart failure. List only	nplications that caused the								2141	Approximating	
	Physician/		Immediate Cause (Final disease or condition	Dono	Nea								Onset and	Death
1	Medical Examiner		resulting in death)	Due to (or as a co	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	0		0.	-000				11218	
		iner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying	b. Eun tulor as a o.		1	-	-69	200				- Second	7
	ecuted and -transi	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to for as a co	onsequence of:		10					- 5	rea	
09	sate be executed physician and the burial-transit	edical I		■ d.										
	tificate ing phy as the	Med	IF FEMALE:											
Box 687	ath cer attendi for use	cian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p 1 Live Birth 2 4 Pregnant at tin	Fetal death 3	Ectopic		у			23d	 Date of deliver Month 	_	Year
	the des	hysic	1 Yes 2 No 9 Unknown	g 🗌 Unknown	ne or death 5 L	o Other (s	specify)							
P.O.	sician: The law requires that the death certific certificate has been signed by the attending rector, page 2 should be detached for use as	Completed by Physician/Me	Part II. Other significant conditions	contributing to death but r	not resulting in the u	nderlying	cause give	en in Part I.				contribute to th		
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eco	e has t	dwa								24a. Was autor perfo	psy ormed?	prior to cor death?	npletion of	cause of
a H	ian: Th	Be C	25. Was case referred to medical examiner?	1		-	26. Pla	ice of Deatl	h (Check		2 X No	1 Tes	2 LJ NO	
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n of	ding F th. After t funera	cate:	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident Investigation	28a. Date of injury (Month, Day, Ye	ear) 28b. Time of injury	М	28c. Injury work?	at ? Yes 2 🗆	- 1	28d. Describe h	now injury oc	curred		
Division of Vital Records, P.O.		Certificate:	3 Suicide 6 Could not 4 Homicide determined	be 28e Place of Injuny	- At home, farm, stre opecify)			103 2 🗆		28f. Location (S City or Tou		umber or Rural	Route Numi	ber,
	lospita t hours uneral ed fillec	Medical	29a. Certifier 1 Certifying Ph	ysician: To the best of my niner: On the basis of exam	knowledge, death o	occured a	it the time,	date and p	place, and	d due to the ca	use(s) and m	nanner as state	d.	anner stated
	the H thin 24 the Fi mplet	Me	only one) 3 Certifying Nu 29b. Signature and title of certifier	rse Practioner: To the bes	t of my knowledge, c	leath occ	urred at the	time, date	and place	e, and due to th	e cause(s) an	nd manner as sta	ated.	
	ნ.≱ნ8		29b. Signature and title of certifier			29	c. License	number \mathcal{T}		>		igned (Month, L cember		2011
			30. Name and address of person who	completed cause of death	h (Item 23a) (Type, P	rint)		1 2	-/		1			
E	T 10+	1		s, MD 971	5 Healt		y Dr	. , Be	erli	n, MD	2181	1		
	Stat Registra	e	William Robin 31. Date filed (Month, Day, Year) SEP 2 7 2	011 32. Registrar's	Signature	ake	1							

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month C Shelly Physician/ 11:15 am Marve 20 Medical 4c. County of Death Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** lt more 8. Date of Birtl g. Birthplace (State or Foreign 7. Åge (In yrs. **74 Funeral** DEPAWARE Min. 1 🗆 M 2 🗶 F Months Hours 6 M4 1 1 9 37 ar) 222-20-5095 Director Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10b. County at 10a. State 10c. City, Town or Location Director the Medical Examiner must be notified 1 Yes 2 No FRANKFORD SUSSEX DELAWARE 10g. Citizen of What Country? 10f, Zip Code ò 10e. Street and Number 19945 US Funeral items 23a 35108 BURBAGE ROAD 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 X Married "natural", or þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates WHITE Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry Important of Health and Mental Hygene.
Important: If item 27 is marked other than any injury or other traumatic event, the Me life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) NONE HOMEMAKER Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) PEARL MCCABE ည WILLIAM ROGERS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 35108 BURBAGE RD, FRANKFORD, DE. 19945 19a. Informant's Name/Relationship (Type, Print) HAROLD E. MARVEL/HUSBAND 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of 1 XBurial 2 Cremation 3 Removal from State ST. GEORGE'S CEMETERY CLARKSVILLE, DELAWARE 9-28-2011 4 Denation S Other (Specify) MELSON FUNERAL SERVICES, LTD 38040 MUDDY NECK RD, OCEAN . Six nature of Fi VIEW. DE. ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, . List only one cause on each line. 23a. Part 1. Enter the dis shock, or heart failu Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or imjury that initiated events Due to (or as a consequence of): and I-transit Exami To the Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 month Month Year Day 5 Other (specify) Pregnant at time of death signed by the a d be detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 2 No 3 Probably 4 Onknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? 1 Yes 2 No this certificate 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) æ examiner? Other: Hospital: 1 Tes 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Impatient 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director; After to completed filled in by the funeral injury Natural 5 Pending Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: To the basis of examination and/or investigation, in my opinion, in each and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 29b. Signature and title of certifier 2011 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) E.T St Suite 5 12-D ristosher 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month (Physician/ Benjamin Madara Medical 4c. County of Death **Examiner** Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 5A2156414 MICOMICO If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** Age 8. Date of Birth (Month, Day, Year) Months **Director** 152-44-7229 59 1 XM 2 🗆 F 06/26/1952 New Jersey Usual Residence of Decedent 28a-f show 10h. County 10c. City, Town or Location 10d. Inside City Limits the Maryland must be notified at Director 1 X Yes 2 No New Jersey Cape May Marmora 23a or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 220 Stagecoach Road 08223 USA and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 **X** No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. "natural", or i þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify If Yes, Give White Completed 3 Widowed 4 Divorced Year or Dates ed other than "natu event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry a 27 is marked other than " r traumatic even" Elementary/Secondary (0-12) College (1-4 or 5+) Owner/operator Trucking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ernest Amos Madara Jr. Laura Belle Crain 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sally Madara (spouse) 220 Stagecoach Rd., Marmora, NJ 08223 Health stem 27 i 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 9/28/2011 Seaside Cemetery Palermo, NJ 21. Signature of Funeral Service Licensee Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner bo Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examine Due to (or as a consequence or burial-transit Due to (or as a consequence of): resulting in death) Last attending physician Box 68760 as the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📈 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe this certificate 1 🗌 Yes 2 🗆 No funeral director, Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? ပ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After work? 1 Natural injury 5 Pending 2 🗌 No Accident Investigation filled in by the Suicide Could not be 3 Suicide
4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of contifier onth. Day. Year

1518 State

Registrar

DHMH 17 Rev 06-2011

egistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 17 per FH 6920 10/2014. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 32514 For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month HATTIE MARIE MEUHAUSER October Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Senator Bob Hooper House Hill Forest Harford 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign 215-42-9589 Hours Davs **Director** 1 🗆 M 2 🗓 F 89 Usual Residence of Decedent Maryland 28a-f show 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director MD. 1 Yes 2 No Harford Jarrettsville 6 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? be items 23a of the must be Funeral Morrisville Road 4025 21084 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. o, by 1 Never Married 2 Married 1 Yes If Yes, Give 3altimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: "natural", Completed 3 X Widowed 4 □ Divorced Specify White Year or Dates er than "natur the Medical B 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Home of Health and Mental Hygie item 27 is marked other other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Milton Schnider ဂ္ Joseph- -Morris----Snyder Hattie Mae Montgomery 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21084 Department of Health ar Important: If item 27 is any injury or other trau Marylin V. Bradford (Dau. 4027 Morrisville Rd. Jarrettsville. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Oct. 1 N Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cem 2011 Joppa. Maryland Union Chapel of Funeral Service Licensee 22. Name and Address of Facility E.G. Kurtz & Son Funeral 71 Jarrettsville. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 I 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ detached for Month Year Dav Pregnant at time of death the 9 Unknown 9 Unknown rate has been signed by r page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Division of Vital Records, 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Funeral Director: After this certificate has autopsy 2 🗌 No Yes 2 No 1 Yes filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 2 No ပ္ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (South 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide or Attending 5 Pending injury work 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) the Hospital 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and tit 29c. License number 30. Name and a rson who completed cause of death (Item 23a) (Type, Print) MONI 300

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Peggie J. Onyeaso September 21, 2011 6:03a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Clinton **Examiner** 4c. County of Death
Prince Georges Southern Maryland Hospital 8. Date of Birth (Month, Day, Year Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 240-76-2212 Months Days Hours Min 1 M 2 S F 63_{Yrs} North Carolina **Director** 1948 13. Usual Residence of Decedent 10a. State 10b. County death with the Maryland 10d. Inside City Limits notified at 10c. City, Town or Location Funeral Director M D Accokeek Prince Georges 28a-f 1XXVes 2 No ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r United States 1119 Ellingwood Drive 20607 items (12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 0 1 Yes 2 X No If Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No Specify: Specify: Black "natural", Completed 3X Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) than alth and Mental Hygiene.
27 is marked other than r traumatic event, the Mo Elementary/Seconday (0-12) College (1-4 or 5+) Health Nurse 2yrs Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Oliver Anderson Nellie В. Powers 19a. Informant's Name/Relationship (Type, Print) item 27 i 1119 Ellingwood Drive, Accokeek, Maryland 20607 Department of Health Important: If item 27 any injury or other t Cleora B. Johnson / daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) Beltsville, Maryland 9/27/2011 Chesapeake Crematory 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility McGuire Funeral Service, Inc. 7400 Georgia Avenue, NW, Washington DC 20012 he 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition MOMON Medical resulting in death) Due to (or as a consequence f): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine B death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year signed by the aid be detached for the To the Hospital or Attending Physician: The law requires that the within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached the completed filled in by the funeral director. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Tes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 100 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury 5 Pending Accident Investigation M 1 ☐ Yes 2 ☐ No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certi 2θc. License number

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State

Registrar

31. Date filed (Month, Day, Year)

27

son who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Dorothy Hilton Owen 09-25-2011 2:00 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Stella Maris Timonium Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min **Director** 220-03-1545 91 1 □ M 2 🛛 F Maryland Yrs 08-05-1920 10c. City, Town or Location Havre de Grace 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Directo Maryland Harford 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States of America 830 Revolution Street 21078 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces No. 1 Yes 2 No. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 🙀 No Specify Specify: White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Real Estate Business Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leslie Earl Hilton Annie Laurie Cox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2090 Chapel Rd., Havre de Grace, Maryland 21078 Laurie Thoner (daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 09-30-2011 Havre de Grace, Maryland Angel Hill Cemetery 21. Signature of Jures 22. Name and Address of Facility Zellman Funeral Home, P.A. 21078 123 S. Washington St, Havre de Grace, Maryland 23a. Part 1. Enter the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) CONGESTIVE HEART FAILURE Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burial-tra that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown Division of Vital Records, P.O. Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 X No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 X No Other: မှ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 TO Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending 1 🗌 Yes Investigation 2 Accident
3 Suicide
4 Homicide Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) e Funeral Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completely (Check within 2 To the 6 3 🗶 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and titl 29d. Date signed (Month, Day, Year) ress of person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

1:50 p.m.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Sophia Elizabeth Phillips Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Paltmore
If Under 1 Year I If Under 8. Date of Birth (Month, Day, **Funeral** Birthplace (State or Foreign Country) 1 🗆 M 2 🔀 F Months Days Hours Min. Director 785-63-5778 08/28/2011 Maryland Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Wicomico Salisbury 1 Tes 2 No 10e. Street and Number 10f. Zip Code er than "natural", or items 23a or the Medical Examiner must be 10g. Citizen of What Country? Funeral 4296 Sturbridge Drive 21804 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n. any injury or other traumatic event, the Medii once. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Şeconday (0-12) College (1-4 or 5+) <u>n</u>|a n a n|a nla Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Kristopher Brooks Phillips Sarah Elizabeth Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kris + Sarah Phillips/Parents 4296 Sturbridge Dr., Salisbury, MD 21804 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Wicomico Memorial Park 10/3/2011 ه∏ ₄ nation 5 Cther (Specify) Salisbury, MD Funeral Servide Mcensee HOLLOWAY Funeral Home Professional Association CFSP 501 Snow Hill Rd., Salisbury, MD 21804 art 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ Congenital disease or condition resulting in death) Medical Due to (or a consequence of): Examiner Sequentially list conditions, if any leading cause. Enter Underlying Due to (unde a nonequence of): physician and the burial-transit requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Live Birth 2 Fetal death
Pregnant at time of death Ectopic pregnancy in the past 12 months?
1 \(\subseteq \text{ Yes} \quad 2 \subsete \text{No} \) 1 Yes 2 2 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Tes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has t autopsy page Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DCA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Could not be 3 Suicide 4 Homicide completed filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number RES 000

Registrar
DHMH 17 Rev 7/2009

State

1000 NWolfe St

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Elizabeth Alexis Charnovich

31. Date filed (Month, Day, Year)

OCT 03

			S	be or Print in E tate of Maryland						
		•	1 - State Registrar			tificate of L			Reg. N2 0 1	1 32518
	Physicia Medic		Decedent's Name (First, Middle, Last) MAUREEN T. PETERS		2. Date of Dear	ber 17	Year 2135 PM			
	Examin	er	4a. Facility Name (If not institution, give street Memorial Hospita	and number)	on !	4b. City, Town, or	Location of Death		4c. County of	
	Funeral Director		5. Social Security Number 057−30−2136 6. Sex 1 □ M	2 X F 7. Age (In yrs. Ia.	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 8/4/19	Year)	9. Birthplace (State or Foreign Country) NEW YORK
	ryland -f show ed at	ctor	Usual Residence of Decedent 10a. State 10b. County	, ,	, Town or Loc	ation				10d. Inside City Limits 1 X Yes 2 □ No
	the Ma a or 28a be notif	Funeral Director	MD TALBOT 10e. Street and Number	EAS	STON	10f. Zip Code			10g. Citizen of Wh	
	ath with	unera	29671 LYONS DRIVE	Vas Decedent Ever in U.S	13 M	2160	l ispanic Origin? (Spe	cify Yes or No-	USA 14 Bace	American Indian,
9800	ge 1 and 2 should be filed within 72 hours after death with the Maryland to 6 Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	۾	1 Never Married 2 Married	Armed Forces? ☐ Yes 2 X No f Yes, Give 'ear or Dates.	1f	Yes, specify Cuba	n, Mexican, Puerto I	Rican, etc.)		White, etc. WHITE
215-(וסל 172 הסן an "nat Medica	Completed	15. Decedent's Educati (Specify only highest grade co Elementary/Seconday (0-12)		(Give k	ent's Usual Occup ind of work done o NOT use retired)	ation during most of working	ng	16b. Kind of Bus	iness Industry
212	iled within I Hygiene. other thar ent, the N	ابها	12	0	HO	MEMAKER			OWN HON	1E
Baltimore, Maryland 21215-0036	should be filed n and Mental Hy is marked oth raumatic event	To B	17. Father's Name (First, Middle, Last) JOHN NANGLE			SCHWENZ	ZER _			
, Mar	nd 2 shou ealth and n 27 is m er traum		19a. Informant's Name/Relationship (Type, P KENAN T. PETERS, S	Oity or Town, Sta	te, Zip Code) 07920					
more	permit. Page 1 and Department of Heali Important: If item 2 any injury or other once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	oval from State C6	emetery, crem	sition (Name of eatory or other place H S CEME	ETERY 9/23	Date // 2011		ity or Town, State A, MARYLAND
Balti	permit. Departn Importa any inju		21. Signature of Funeral Service Licensee	ERCEROS	17	Name and Addres	ss of Facility IELFENBEIN HARRISON	& NEWN	AM FUNER	AL HOME, P.A.
			23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one can immediate Cause (Final	ons that caused the death				r respiratory arre		Approximate Interval Between Onset and Death
- May	Ph. sician/ Medical Examiner		disease or condition resulting in death)	Due to (or as a consequent	ence of):	00	Mario			
7		al Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying	Due to for as a conseque	ence of:	<i>[12 .</i>				
0	be executed sician and burial-transit		Cause (Disease or iinjury that initiated events c resulting in death) Last	Due to (or as a consequ	ence of):					
98760	rtificate ing physe as the	/Medi	d							
Division of Vital Records, P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate E within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the temperal page.	Physician/Medic	in the past 12 months?	f yes, outcome of pregnar Live Birth 2 Fetal Pregnant at time of d Unknown	cy			Date of delivery Month Day Year		
ls, P.0	uires that the signed by all the deta	by	Part II. Other significant conditions contribu	uting to death but not resu	ulting in the u	nderlyin g cause gi	ven in Part I.		oute to the cause of death?	
Secor	he law req ite has bee iage 2 shou	Completed						24a. Was a autop perfor	pr rmed? de	ere autopsy findings available ior to completion of cause of eath? Yes 2 No
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of Vi	Physi r this c eral din	e: 10	1 Li res 2 latino	1 Inpatient 2 8a. Date of injury	28b. Time of	28c. Injur	4 ∐ Nursing Ho y at		lence 6 Other	
ion	tending eath. or: Afte the fune	Certificate:	1 Natural 5 Pending (Month, Day, Year) injury work? 2 Accident Investigation 3 Suicide 6 Could not be							
Divis	Hospital or Attend 24 hours after death Funeral Director: A eted filled in by the fi		4 Homicide determined	0.	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	he Hospi in 24 hou he Funer	Medical	29a. Certifier 1 Certifying Physician (Check 2 Medical Examiner: Conly one) 3 Certifying Nurse Pra	on the basis of examination	and/or invest	igation, in my opini	on, death occurred at	the time, date a	nd place, and due	to the cause(s) and manner stated.
	To the within 7 To the Comple		29b. Signature and title of certifier	M.D.		29c, Licens			29d. Date signed	(Month, Day, Year)
	Q		30. Name and address of person who comple	eted cause of death (Item	23a) (Type, P	rint)	265656 Wesh	p-lin	Street.	Easter MO216
	Stat		31. Date filed (Month, Day, Year) SFD 2.0 2011	32. Registrar's Signat	" Soc	Mar	3	1		

Please Type or Print in Black Indelible ink Frayre All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ 09-13-2011 11:15 P M James Caverly Newlin Paul Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Talbot 1352 Chancellor Point Rd Trappe Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 8. Date of Birth 7. Age (In yrs. last birthday) Days Hours Min. 04-30-1926 1 XM 2 □ F 85 PA Director 159-20-7676 Yrs. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified to once. 10d. Inside City Limits 10b. County 10c. City, Town or Location Director 1 Yes 2 X No MD Talbot Trappe 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral USA 1352 Chancellor Point Rd 21673 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 X Yes 2 ☐ No Black, White, etc 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Higher Education Law Professor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Adelaide Newlin William A.B. Paul 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Wife) Margaret C. Paul 1352 Chancellor Point Rd Trappe, MD 21673 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) Chesapeake Cremation 9-16-2011 4 ☐ Donation 5 ☐ Other (Specify) Stevensville, MD 21. Signature of Full / Service Licensee 2 Name and Address of Facility, ellows, Helfenbein & Newnam Funeral Home P.A. 00 S. Harrison St. Easton MD 21601 ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Sonset and Death 23a. Part 1. Enter the disease, or complications that day shock, or heart failure. List only one cause on each PROSTATE CANCER Prosician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? certificate has been signed by the atterector, page 2 should be detached for Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 🗌 Yes 2 🗆 No ☐ Yes ≥ 25. Was case referred to medica 26. Place of Death (Check only one) the funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manper of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? Natural 5 Pending injury Accident 3 Suici 2 🗆 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide mpleted filled in by determined City or Town, State) Medical 29a. Certifier 车 rtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Gartifying Nurse Fractioner: Tult 29b. Signatu D39887 9-14-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David H. Smith, MD 8221 Teal Drive, Ste. 301 Easton, MD 21601 15+VA

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (MSEP 19 2011

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 32520 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 2000 Physician/ ERTICONE 201 HRISTOPHER Morth Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Anne Arundel Annapolis 5. Social Security Number If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** 1 ₺ M 2 🗆 F 82 Months Days 577-36-1778 Month Pay, Year) 28 Yrs Director Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director ems 23a or 28a-f sh r must be notified a 1 🗌 Yes 🗶 No Anne Arundel Annapolis MD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 556 Choptank Cove Ct. 21401 USA death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, the Medical Examiner Armed Forces' Black, White, etc. ō ģ 1 Never Married 2 Married XX Yes 2 If Yes, Give 2 No 1949-3altimore, Maryland 21215-0036 and 2 should be filed within 72 hours after White 1 Yes 2 TNO Specify. Completed Specify "natural" 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Service Station Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Filippina Strazanna Louis Perticone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Perticone Wife 556 Choptank Cove Ct. Annapolis, MD 21401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 a TXXBurial 2 Cremation 3 Removal from State 9/23/2011 Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cem 22. Name and Address of Facility Hardesty Funeral Home, P.A. Signature of Funeral Service Vice Annapolis, MD 21401 12 Ridgely Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ neu mom as disease or condition resulting in death) Medical Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) -transit death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): physician a sthe burlal-Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Year Pregnant at time of death signed by the a g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by pe 1 ☐ Yes 2 Z No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law eral Director: After this certificate has filled in by the funeral director, page 2 s autopsy performe performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Other: ဂ္ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Matural 5 Pending injury work? 1 ☐ Yes 2 ☐ No hours after death Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Funeral Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. pleted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 24 (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) Signature and title 29d Pate signed (Month, Day, Year) 29c. License number N438

DHMH 17 Rev 7/2009

State

Registrar

VICHAEL

31. Date filed (Month, Day, Year)

WM 441

32. Registrar's Signature

ANNAPOLIS MOZIYOI

Hwy

Name and address of person who completed cause of death (Item 23a) (Type, Print)

SEP 2 6 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 32521 For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year L 0720 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 20751 6045 A Melbourne Ave. Deale Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 M 2 D F 58 Davs Hours 373-60-0379 11/6/1952 Director Vrs Michigan Usual Residence of Deceden 28a-f shov 10a. State 10b. County 10c. City, Town or Location with the Maryland **Funeral Director** 10d. Inside City Limits must be notified 1 Yes 2x No MD Anne Arundel Deale 0 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a 20751 USA 6045 A Melbourne Ave. items death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc ō ģ 1 Never Married 2 XXMarried 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after White 1 ☐ Yes 2 ☒ No Specify: "natural", Completed 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) than Elementary/Seconday (0-12) College (1-4 or 5+) Department of Health and Mental Hyginal Important: If item 27 is marked other tha any injury or other traumatic event, the Aonce. Satellite Industry 5+Senior Systems Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Eleanor Boronski Paul Bernard Pokryfki 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Retha Solar Pokryfki Wife 6045 A Melbourne Ave. Deale, MD 20751 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Atlantic Crematory 9/22/2011 Glen Burnie, MD 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Service Licensee Annapolis, MD 21401 Ridgely Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one caus Interval Between onset and Dec Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) b Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Property of the pro ng physician and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: yes, outcome of pregnancy use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Pregnant at time of death Day Year detached 9 Unknown signed by Part II. **Other** s**ignificant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pe 2 No 3 Probably 4 Unknown 1 Yes peen Was an 24b. Were autopsy findings available prior to completion of cause of this certificate has ral director, page 2: autopsy performe death? Yes 2 1 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital ٥ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation filled in by the 6 Could not be Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the 3 only one) within To the 29b. Signature and title of certifier 29d-Date signed (Month, Day, Year) Name and address of person who completed caus death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year) SEP 2 6

VOID

Thomas Palenchar

certificate no.: 2011-32522

copy of certificate was rec'd and not original. Original was already fited prior to.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 5:33рм **Physician** Mary Frances Quillin eptember 22 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Somerset Manokin Manor Inder 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth **Funeral** 1 □ M 2 🕇 F 02 28 1920 213-14-1340 91 Director Usual Residence of Decedent within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits than "natural", or items 23a or 28a-f show injury or other traumatic event, it e Mudical Examiner must be notified at Director 1 XYes 2 ☐ No MD Wicomico Salisbury 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1514 Riverside Dr. Apt. C218 21801 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∏Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No Specify Specify: 3 XWidowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiens Important: If them 27 Is marked other the any injury or other traumatic event, it and once. Nurses Aide Healthcare 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Stanley Lory Phillips Martha Brewington 9-22-2011 ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughter 26708 Mt. Vernon Rd., Princess Anne, Md., 21853 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 09 26 2011 Salisbury, MD Shad Point Cemetery 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Holloway Funeral Home P.A. 21. Signature of Funeral Service I 501 Snow Hill Rd., Salisbury, MD, 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **♥** Physician ASCVI disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Lisease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 Ectopic pregnancy in the past 12 months? Day Year 5 ☐ Other (specify) signed by the a 1 ☐Yes 2 ☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed certificate has b irector, page 2 sh 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy 2 1 No 1 ☐ Yes 2 □No 1 □ Yes director 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To funeral 27. Mannet of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 3 ☐ Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 247094 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5. DIVISIUN 1415 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 32524 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Florence Rosenberg 1515 September 15, 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery 3200 N. Leisure World Blvd. Apt. 505 Silver Spring If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Davs Hours 108-20-6396 **Director** 1 □ M 2 🛛 F 84 Sep. 10, 1927 NY 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location items 23a or 28a-f sho her must be notified at Director 1 X Yes 2 □ No Silver Spring Montgomery Md. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 20906 3200 N. Leisure World Blvd. Apt. 505 death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Examiner Armed Force Black, White, etc. or þ 1 Never Married 2 Married 1 ☐ Yes 2 👿 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 within 72 hours after White 1 ☐ Yes 2 🔀 No Specify "natural", Completed 3 X Widowed 4 ☐ Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. University Professor Elementary/Secondary (0-12) College (1-4 or 5+) Consulting Sociologist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental H ൧ Harry Rafman Duberman Dora other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 i 10113 Ashburton Lane Bethesda, Md. 20817 Paul Rosenberg-Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite 😾 Burial 2 🗆 Cremation 3 🗆 Removal from State any injury or 4 Donation 5 Other (Specify) Menorah/Parklawn 9/18/2011 Rockville, Md. Signature of Funeral Service Licensee 22. Name and Address of Facility Moo910 Danzansky-Goldberg Memorial Chapels 1170 Rockville Pike Rockville, Md., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final) Onset and D Minutes Physician/ disease or condition resulting in death) Cardiac Arrhythmia Medical Due to (or as a consequence of Examiner Years Atrial Fibrillation Paroxysma1 Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 phy nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy jo in the past 12 months?
1 ☐ Yes 2 ☒ No Dav 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed d be det þ Hyperlipidemia 1 Yes 2K No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Hypertension 24a, Was an page 2 autopsy 2 X N funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔀 No 1 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 X Natural 5 Pending within 24 hours after death. To the Funeral Director: A 2 No Investigation Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check

To the Hospital mpletely

> State Registrar

31. Date filed (Month, Day, Year) **SEP 22** 2011

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29b. Signature and title of certifier



Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

D34740

29d. Date signed (Month, Day, Year)

9/16/2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney N 32525 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2011 Linda Maria Rosenberger 21 8:10 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Atlantic General Hospital Berlin Worcester 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 1 🗆 M 2 🔀 F Months Days Hours Min. **Director** 58 219-60-6963 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director 1 ☐ Yes 2 🛛 No MD Worcester Ocean Pines 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 141 Ocean Parkway USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important if item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exa 1 Yes 2 No Specify: 3 🖾 Widowed 4 🗆 Divorced Specify: white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Office Manager Clerical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Jones Clark Richardson Annelise Linde 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joy Stortz / daughter 1245 Chipmonk Ln., Easton, PA 18040 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗷 Burial 2 🗌 Cremation 3 🗀 Removal from State Garden of the Pines 9/26/11 Ocean Pines, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Septice Licensee Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) eclon concer / Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a consequence of): requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year 1 Yes 2 2 9 Unknown Pregnant at time of death ed by the a detached f g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, Sepsi's 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? performed? Yes 2 No 2 X No 1 Yes Hospital or Attending Physician: Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 Tyes 2 No Other: မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 2 Accident 5 Pending 1 Tes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the l within 2 To the l only one) 29b. Signature and title of certifier 29c. License number 10064120 09/21/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
A tif Zeeihan Aalt 9733 Heal th way Drive Bestin MD 21811. BA 10 31. Date filed (Month, Day, Year) State 32. Registrar's Signature Registrar SEP 27

DHMH 17 Rev 7/2009

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Lynne

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 32526 Reg. N2 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. 34 P_M 2. Date of Death Physician/ Month Rodgers Marie Suzanne Medical Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Charles Medical Center a 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 04-22-1934 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🛛 F Months Ohio Director 442-36-6963 Usual Residence of Decedent shov 10a. State 10b. County event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 Yes 2 X No MD Anne Arundel Lothian ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 33 Daniel Drive USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. than "natural", or ۾ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 X Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) store clerk retail is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental 2 Rov Fe1ty Lilley Μ. Rhodus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other traconce. Kathie Lynn Henderson, friend 33 Daniel Drive, Lothian, MD20711 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 8-20-11 Alexandria, VA . Signature of Juneral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list nondition Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Fctopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month Year 5 Other (specify) Day page 2 should be detached Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an the Funeral Director: After this certificate has impleted filled in by the funeral director, page 2 s autopsy performed? Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) No Hospital 1 🗌 Yes Other: 2 ၉ 1 Inpatient ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined within 24 hours a To the Funeral I 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nyfse only one practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. nd title of certifier 29c. License number ne and address death (Item 23a) (Type, Print) who completed cause of 31. Date filed (Month, Day, Year) AUG 22 2011 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 32527 Reg. No. U Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 09 Physician/ $\overset{\scriptscriptstyle{\mathrm{Year}}}{20}11$ 10:25P M Frank Robert Rowe Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Anne Arundel Annapolis 2790 Rudder Drive If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 **X** M 2 □ F Days Hours 05/04/192<u>3</u> New Jersev 88 144-14-6872 **Director** Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State must be notified at 1 ☐ Yes 2X No Anne Arundel Annapolis Maryland ۵ 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23a United States Funeral 21401 2790 Rudder Drive "natural", or items edical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 Never Married 2 X Married by Baltimore, Maryland 21215-0036 If Yes, Give WWII 1 ☐ Yes 2 🛣 No Specify Specify: White 3 Widowed 4 Divorced Completed traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry should be filed within 72 h. h and Mental Hygiene. --دما م**ther than "r** (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Construction Mechanical Engineer 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Antoinetta Catania Angelo Rocco 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2790 Rudder Drive, Annapolis, Maryland 21401 Dorothy Rowe/Wife f Health injury or other 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 Department of I Important: If it any injury or o oţ Gate of Heaven Cem. 1 Burial 2 Cremation 3 X Removal from State 09/27/2011 East Hanover, NJ 4 Donation 5 Other (Specify) Signature of Femeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) of thyroid Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury burial-transit that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Box 68760 IF FEMALE nse 23d. Date of delivery 23b. Was decedent pregnant jo in the past 12 months? Year Month Day 1 Yes 2 No g Unknown the P.O. ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 4 Unknown Records, 1 Yes 2 No 3 Probably eyp, tive impairment 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No certificate sompleted filled in by the funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Division of Vital Be 26. Place of Death (Check only one) Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 🗌 Nursing Home 5 Residence 6 Other (Specify) After this Magner of Death 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Medical Certificate: Hospital or Attending 5 Pending 1 Yes 2 🗌 No Accident Investigation 24 hours after deat Funeral Director: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 29b. Signature and title of certif use of death (Item 23a) (Type, Print) ,139 Old Solomons Island Road, Annapolis, MD 21401 31. Date filed (Month, State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month James H. Rhine Sept 2011 12:20 PM Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Talbot Easton Genesis HealthCare -The Pines If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) **Pa** 7. Age (In yrs. last birthday) **Funeral** 164-09-2148 Months Days Hours Min. 12///on2994x, Y1918 92 Director Pa. Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Talbot Easton Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 610 Dutchmans Lane 21601 U.S.A. 12. Was Decedent Ever in U.S.
Angled Forces?
14 Yes 2 If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Page 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin ğ 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: White Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)
Retail Sales 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12College (1-4 or 5+) Petroleum Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Rhine Sarah J. Yardlev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard A. Rhine / Son 10442 Claiborne, Rd. Claiborne, Md. 21624 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Crematory of De marva 9-20-2011 Delmar, De. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses Humbery Aldre Ostrowski Funeral Home P.A. Joseph P.o. Box 518 St. Michaels, Md. 21663 Ofraski 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Seven Physician/ Immediate Cause (Final Onset and Death disease or condition resulting in death) CHFEXALESBATIN Medical Due to (or as a consequence of) **Examiner** ENDSTAGE CHE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury been signed by the attending physician and should be detached for use as the burial-tran: that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by major depression, failure to thrive 1 Yes 2 No 3 Probably 4 Hinknown has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an umbar Sterrosis within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 101 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number

State Registrar

6+ VA

CRNP

EASTON MA 21601

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GLIA

Registrar's Signati

1-07386		Please Type or Print in Black Indelibl			ble.	00500			
Cheryl Snyder		State of Maryland / Departmen		ygiene	2011	32529			
		Registrar	e of Death	Reg.					
Physici Medical Exam		1. Decedent's Name (First, Middle, Last)			ay Year	3. Time of Death 1151 hrs			
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	October 2, 2	4c. County of Death				
<i>A</i>		301 Hospital Drive	Glen Burnie		Anne Arundel				
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birth							
Director		217-62-9730 1VM 20F 5/-	Yrs. Months Days Hours Min.	9-10-5	Foreigr Cou	intry) MD.			
		Usual Residence of Decedent		10 0		, (1).			
v any		10a. State 10b. County 10c. City, Town or Location							
Maryland 28a-f show d at once.	ō	MD. ANNEARINDEL G			1 Yes 2 No				
Mary 28a-	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Coun	try?			
ith the Maryland 23a or 28a-f she notified at once	<u> </u>	7613 QUARTERFIELD RD.	21061		U.S.	A			
th wit ems 2 t be p	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13 1 Never Married 2 Married Armed Forces?	B. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto		14. Race - Americ White, etc.	an Indian, Black,			
er dea	<u> </u>	1 Yes 2 No							
rs afte ural", mine	ģ	3 Widowed 4 Divorced If Yes, Give Yeer or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Dec	Yes 2 No specify: edent's Usual Occupation (Give kind of v	rork done 116	Specify: Sb. Kind of Business/Ir	ndustry.			
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5-0036 led within 72 hours a Hygiene. other than "natura the Medical Examin	Completed	17. Father's Name (First, Middle, Last)		(First, Middle, Mai	den Surname)	2011016			
	Be	STEVE W. BENNETT	Agnes	GAN	NON				
ID 21 should and Me 77 is ma	6		ailing Address (Street and Number or F	tural Route Numbe	r, City or Town, State,	Zip Code)			
a baland		NICOLE SANDER, DAUGHTER 134 20a, Method of Disposition 20b, Place of Di	sposition (Name of cemetery,	OKLYN IAA	K, MD・と12 0c. Location - City or T	- 1907			
imore, MD 2121 Pages 1 and 2 should be fi ment of Health and Mental tant: If item 27 is marked or nther fraumatic event,			or other place)	Date 2	oc. Location - City or	Town, State			
timent trant:		4 Donation 5 Other Specify: W. ARNS	C - 1 - 1 1 1 1 1	5-11 6	DDENTON	MD.			
Baltimore, permit. Pages 1 a Department of He Important: If ite injury or nther tr		21. Signature of Funeral Service Ideensee			YFUNERA	HOME			
Physician	2	23a. Part I. Enter the disease, or complications that caused the death. Do not en			shock or heart	Approximate Interval			
/Medical		failure. List only one cause on each line.				Between Onset and Death			
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Complications of Complete	ocarne and narcocre	use					
		Sequentially list conditions, b							
	Examiner	if any, leading to immediate Due to (or as a consequence of):							
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6 H 7 I	dic	x unpended ☐ amended 23a,27,per mo	e,g920 10-17-11 sm						
ox 68760, eath certificate be ex attending physician or use as the burial-	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery				
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Box 68760, e death certificate be the attending physical of or use as the burned for use	Physician/Medi	1 Yes 2 No 9 V Unknown 9 Unknown	Other (Specify)						
~ # ≥€		Part II. Other significant conditions contributing to death but not resulting in t	the underlying cause given in Part I.	23e. Did toba	cco use contribute to the	he cause of death?			
s, P.C iires that signed!	d by			1 Yes	2 No 3 Proba	ably 4 🗸 Unknown			
ords v requ	ete	·		24a. Was an autopsy		opsy findings available ompletion of cause of			
lecc The lay ate ha	Completed			performe		2 No			
Division of Vital Records, rat mr Attending Physician: The law requirers after death. al Director: After this certificate has been sided in by the funeral director, page 2 should be a possible to the funeral director, page 2 should be a possible to the funeral director.	Bec	25. Was case referred to medical	26.Place of Death (Check of	only one)					
bysici	o۱	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpat	tient 3 DOA Other Nursing	Home 5 Re	sidence 6 Other:				
n of ling P After funera	Ë	27. Manner of Death 1 X Natural 5 Deadies 28a. Date of Injury (Month, Day, Year) 28b. Time	· · · _ · · _	28d. Describe how	injury occurred				
SiOr oftend death ctor: y the	ăţį	2 Accident Investigation	1 Yes 2 No						
Jivis Inr A	Certification:	3 Suicide 6 Could not be determined (Specify)	street, factory, office building, etc.	28f. Location (Stre or Town, State	et and Number or Rur. e)	al Route Number, City			
Dispital 1 hours a meral 1 y filled		4 Homicide							
the Hosin 24 h	Medical	(Check only one) 1 Certifying Physician: To the best of my knowledge, death o one) 2 Medical Examiner: On the basis of examination and/or investigation.							
To To Com	Wed	and manner stated. 29b. Signature and title of certifier	29c. License number		9d. Date signed (Mon				
	-	04072	O.C.M.E.		October 3, 2011	. ,,,			
		30. Name and address of person who completed cause of death (Item 23a)			-,				
		Ana Rubio MD. Assistant Medical Examiner 900 W. B	Baltimore Street, Baltimore, MD	21223					
St	ate	3 Page filed (Non Page Year) 32. Redistrar's goodly							
Regist		UCI I & CUIT CENEVA P. 19 March							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ SEPTEMBER Day 26 2011 SHAREEF ALI SHREIDI 4:51 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death c. County of Death MONTGOMERY NATIONAL INSTITUTES OF HEALTH **BETHESDA** ocial Security Number 6. Sex 8. Date of Birth (Month, Day, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) United Arab Emirate 7. Age (In yrs. last birthday) **Funeral** Days Min. 050-86-6349 1 🛛 M 2 🗆 F 29 Yrs Director Dec 1981 Arab Usual Residence of Decedent 10a. State N Y "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10b. County Suffolk 10c. City, Town or Location Commack 10d. Inside City Limits Funeral Director 1 ☐ Yes 2 🕱 No 10e. Street and Number 10g. Citizen of What Country?
USA / Lebanon 10f. Zip Code 68 Pawner 11725 Dr. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces Black, White, etc. Completed by 1 X Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: If Yes, Give Specify: Asian 3 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) unemployed none Be 17. Father's Name (First, Middle, Last) 18. Mother's Name *(First, Middle, Maiden Surname)* Montaha Haleem Shreidi ည Ali Shreidi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bob Elkhatib /uncle 68 Pawnee Dr. Commack, NY 11725 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Family Cemetery 1 💆 Burial 2 🗆 Cremation 3 🔀 Removal from State Beirut, Lebanon 9/29/2011 4 ☐ Donation 5 ☐ Other (Specify) Universal Mortuary 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 20011 411 Kennedy St NW Washington, DC Kaser 23a. Part 1. Enter the dilease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a conse **Examiner** Acomt4 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of): E STATE OF THE STA that the death certificate be executed BHOMG that initiated events Due to (or as a consequence of): resulting in death) Last physician a sthe burial-Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Pregnant at time of death Day Year signed by the a Id be detached f 1 ☐ Yes 2 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 23e. Did tobacco use contribute to the cause of death? To the Hospital or Attending Physician: The law requires t within 24 hours after death.

To the Funeral Director: After this certificate has been sign perpeted filled in by the funeral director, page 2 should be 2 160 1 Tyes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perforn death? 2 🗆 No Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 XNo 1 🗌 Yes Other: 1 Depatient 2 ER/Outpatient 3 I မ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manper of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature d title of certifier 26 201

Registrar DHMH 17 Rev 7/2009

State

30. Name and address of peg

31. Date filed (Month, Day,

Box 68760

P.O. I

Records,

Division of Vital

10 CENTER DRIVE, BETHESDA, MD

20892

on who completed sause of death (Item 23a) (Type, Print)

registrar's Signature

KAR UNO

32.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ sept.22,2011 Year 11:00a M Edward John Savage Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number If Under 1 Year | If Under 24 Hrs. 6 Sex 7. Age (In vrs. last birthday Date of Birth Funeral 9. Birthplace (State or Foreign Hours 071-18-2850 89 872271922 New York 1 🔀 M 2 🗆 F Director 10a. State 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director ms 23a or 28a-f s must be notified Montgomery 1 Yes 2 No MD Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3620 Littledale Road #313 20895 USA "natural", or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Arms 2 No WWII Completed by 1 Never Married 2 Married Black White etc permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinonce. Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: 3 Divorced If Yes, Give Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Foreign Service Officer Elementary/Secondary (0-12) Collage (1-4 or 5+) Dept.of State Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Seth Savage unknown 19a. Informant's Name/Relationship (*Type, Print*) Peter Kilborn Savage/Son 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2114 Cascade Road Silver Spring, Md 20902 20a. Method of Disposition
1 □ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crem. 9/27/2011 Beltsville, Md. PHNLEP & Des RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd. Silver Spring, Md20910 uneral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death days Immediate Cause (Final Physician/ Acute myocardial infarction disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Acute renal failure wks Sequentially list conditions, Examiner Acute liver failure cause. Enter Underlying Cause (Disease or injury wks To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Septic shock wks Division of Vital Records, P.O. Box 68760 the as IF FEMALE: USE 23b. Was decedent pregnant | Live Birth 2 | Fetal death 3 | Ectopic pregnancy | Pregnant at time of death 5 | Other (specify) | 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year the 9 Unknown After this certificate has been signed by i funeral director, page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by End stage Alzheimer's dementia 1 Tes 2 No 3 Probably 4 H Unknown Urosepsis 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 AN 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 \(\text{Yes} \) 2 **X**No Other: ဂ္ 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at within 24 hours after death.

To the Funeral Director: After of the funer completely filled in by the funer 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 9 / 22 / 2011

State Registrar

L

31. Date filed (Month, Day, Year) SEP 27 2011

Suranich Ru. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Parbaca

Barbara Supanich MD 1500 Forest Glen Rd Silver Spring, Md 20910

D0065485

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 32532 For State Registrar AMEND#9perINF, 9/30/11; BMW, McCo Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 19, 2011 Sickler 3:30 am Barbara Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Renaissance Gardens - Riderwood Prince George's Silver Spring 9. Birthplace (State or Foreign Massachuset ts Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) Date of Birth 1 M 2 X F Months Hours Min. 8972271917 274-36-8550 Director Usual Residence of Decedent 10a. State with the Maryland 10b County 10c. City, Town or Location Director 10d. Inside City Limits notified 28a-f Silver Spring Maryland Prince George's 1 Yes 2 X No ms 23a or must be r ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20904 3160 Gracefield Road U.S.A. be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ıral", or iten I Examiner 14. Race - American Indian, Black, White, etc. by 1 ☐ Yes 2 🕱 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 'natural" Completed 3 X Widowed 4 Divorced White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Health Care/Education Executive Secretary of Health and Mental Hygi item 27 is marked othe other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Sadie Clark Henry Prenier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if item 27 i Donald Sickler - Son 6959 Rosecliff Place, Dayton, Ohio 45459 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State George Washington Cem 09/30/2011 Adelphi, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
O Years Immediate Cause (Final Ph sician/ Alzheimer's Dementia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of). that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Por Month Year Day Pregnant at time of death the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Arteriosclerotic Cerebral Vascular Disease 1 ☐ Yes 2 🗓 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 X No 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 2 X No Other: ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 X Nursing Home 5 Residence 6 Other (Specify within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🗶 Natural 5 Pending injury work? 1 🗌 Yes 2 🗌 No Accide Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1581de

Registrar

State

3160 Gracefield Road, Silver Spring, Maryland 20904

son who completed cause of death (Item 23a) (Type, Print)

Registrar's Signatu

CRNP,

Eileen Gemmell, 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 32533 Reg. No. U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Magh-14-2011 1335 Namusa Sesay Medical 4a. Facility Name (if not institution, give street and number)
Holy Cross Hospital 4b. City, Town, or Location of Death Silver Springs c. County of Death Montgomery Examiner 6. Sex 7. Age (In yrs. last birthday) 71 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth (Month, Day, **Funeral** 579-19-9324 Hours 1 □ M 2 🕇 F **Director** 1 - 1 - 1940Sierra Leone ms 23a or 28a-f show must be notified at 10c. City, Town or Location Beltsville State Md. 10b. County 10d. Inside City Limits Director PG X 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4720 River Creek Terrace 20705 Sierra Leone ral", or items? filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 X No Specify: "natural", 3 ★ Widowed 4 □ Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 73 ment of Health and Mental Hygiene. ant; If Item 27 is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Vendor Vending traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Bassie Sesay Sattie Sesay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4720 River Creek Terrace, Beltsville, Md. 20705 Barrie-Daudhter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If it any injury or o once. cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State Maryland National: 9-18-11 4 ☐ Donation 5 ☐ Other (Specify) Laurel, Maryland 22. Name and Address of Facility 411Kennedy St, N.W. ure of Funeral Service Universal Mortuary Inc,Wash,D.C. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Onset and Death Ph_sician/ Cachexia Medical resulting in death) Due to (or as a consequence of): Examiner Peritoneal Carcinomatosis Sequentially list conditions, it any leading to immediate cause. Enter Underlying Examiner Ovarian Cancer Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) attending physiciar as the bur Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy☐ Pregnant at time of death 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 🛣 No
9 ☐ Unknown ō Month Day Year detached the þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed?

1 Yes 2X No death? within 24 hours after death.

To the Funeral Director. After this certificate it pompletely filled in by the funeral director, page 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 🗆 XNo Other: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d, Describe how injury occurred Certificate: work?
1 Yes 2 No Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and ti 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 06-201:

State Registrar of death (Item 23a) (Type, Print)

person who completed gaus

30. Name and address b

Maria

Tayag,

D63579

Ĭ500 Forest Glen Rd,Şilver Springs,Md. 20910

9-14-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City. Town, or Location of Death County of Death 5540 Harford St. Churchton Anne Arundel Social Security Numbe If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Days 1 M 2 □ F Min Hours 235-54-5661 8/12/1939 **Director** 72 Usual Residence of Decedent or 28a-f show 10a. State with the Maryland must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Anne Arundel Churchton 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 5540 Harford St. 20733 USA Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever In U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14. Race - American Indian. ō þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 "natural", 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) nt of Health and Mental Hygiene.

If item 27 is marked other than or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Elevator Mechanic Building Maintenance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ronald Sheets Eva DeVilder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ellen Sheets / Wife 5540 Harford St., Churchton, MD 20733 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) Department o Important: If any injury or 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Kalas Crematory 9/26/2011 Edgewater, MD 21. Si natur unera Service licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Fh_sician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Exami signed by the attending physician and I be detached for use as the burial-transit The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b Completed plnous 1 Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate Yes 2 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) 1 🗌 Yes 2 No Other မ 1 Inpatient 2 ER/Outpatient 3 DOA Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work?
1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A ☐ Accident ☐ Suicide Investigation 6 Could not be filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 24 Pertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Defense Hury ANNAPOLIS MO 2140 SENEVIOVE 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar & QO Certificate of Death 1. Decedent's Name (First, Middle, Last. 2. Date of Death 3. Time of Death Month 09 Physician/ 325 Bernice Savage Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Shack Truma Bultimore If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Davs Min. 1 🗆 M 2 🕏 Months Hours (Month, Day Director 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits **Funeral Director** must be notified Seaford bussex 1 Yes 2 No or 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? items 23a onwe 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. Armed Force o ģ 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 Wo Specify: "natural", Completed 3 Widowed 4 Divorced Specify: Year or Dates lact Medical 15 Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maider, ပ annon orman 19a. Informant's Name/Relationship (Type, Print) or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location -1 🗆 Burial 2 Cremation 3 - Removal from State crematory or other place. Donation Other (Specify) Signature of Fundal Service Licenses 22. Name and 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Hospital or Attending Physician: The law requires that the death certificate be executed ng physician and as the burial-tran that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: use a yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) for in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death Month detached 9 Unknown Unknown been signed by should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy page ; performed death? 2 🗌 No 1 Yes 2 2 funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 No Other: ၉ 1 Inpatient ER/Outpatient 3 D 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural 5 Pending (Month, Day, Year) death. 1 Yes Investigation Accident Funeral Director: completed filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 29a. Certifier crtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the F only one 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

To l

DHMH 17 Rev 7/2009

State

Registrar

30. Name and address of person who completed cause of death (4em 23a) (Type, Print)

09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 09-14-2011 Jean Allison Smith 9:17 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 4360 Baildon Rd Trappe Talbot 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Months Days Hours Min. 82 05-18-1929 469-28-4088 Illinois Director Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Talbot Trappe 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 4360 Baildon Rd 21673 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. ρ 1 Never Married 2 X Married 1 ☐ Yes 2 🔀 No If Yes, Give 3altimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 👿 No Specify: 3 Divorced 4 Divorced Specify: White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene, is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Freelance Artist Fine Arts Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked Glen Ranney Mildred Birdseye 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert A. Smith (husband) 4360 Baildon Rd Trappe, MD 21673 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Chesapeake Cremation Center 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify 9-15-2011 Stevensville, MD of F mal Servi Sign P.A. Per and Address of Facility Fellows, Helfenbein & Newnam Funeral Home P.A. 200 S. Harrison St Easton MD 21601 any Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onse D+th Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Due t (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) be detached for in the past 12 months? Month Pregnant at time of death Yes 2 9 Unknown 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 s autopsy performed prior to completion of cause of death? 2 40 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Presidence 6 Other (Specify 1 🗌 Yes 2 46 ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 \square Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of ce son who completed cause of death (Item 23a) (Type, Print)

Carolyn Relmly, MD 508 Idlewild Eas

Easton MD 21601

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			for State Registrar	State of M	aryland / I	Department (Certificate (/lental Hy	/giene Reg. N	2011	32537
	Dhysici	· · · /	1. Decedent's Name (First, Middle						2. Date of De	eath		3. Time of Death
	Physicia Medi	cal	SUSAN IDON						septe1			
	Examir	ner	4a. Facility Name (if not institution				vn, or Locatio	on of Death		40	c. County of Dear	h
	Funeral		UNION HOSPITAI 5. Social Security Number	6. Sex 7. Ac)UNTY e (In yrs. last birt	hday) If Under 1	Year If Und	der 24 Hrs.	8. Date of Bi	irth ,	CECIL	tholage (State or Foreign
	Director		221–28–3152	1 □ M 2 😿 F	67	Yrs. Months D	ays Hour	rs Min.	(Month, D.) JULY 3(3, Year)	44 DEI	AWARE
	and show	ō	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location						10d. Inside City Limits
	Marylk 28a-f s	rect	MARYLAND CEC	IL		NORTH EA	ST					1 ☐ Yes 2🗓 No
	h the	al Di	10e. Street and Number			10f. Zip Co				10g. C	itizen of What Co	ountry?
	ms 2%	Funeral Director	98 PLUM CRE	EK ROAD 12. Was Decedent	Dues in U.O.	I to Mar Danadari	2190		-if . V-a av Na		NITED ST	
ဖွ	er des or ite miner	by Fi	11. Marital Status 1 □ Never Married 2 🏋 Mar	Armed Forces?		13. Was Decedent If Yes, specify	Cuban, Mexi	ican, Puerto	Rican, etc.)) -	14. Race - Ame Black, Whit	
21215-0036	e filed within 72 hours after death with the Maryland tal Hygiene. 4d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		3 Widowed 4 Divorced	If Yes, Give Year or Dates.		1 ☐ Yes 2X	XNo Spec	cify:			Specify: W	HITE
15-(72 hou n "nat Tedica	Completed	(Specify only highe	nt's Education st grade completed)	16a.	Decedent's Usual O (Give kind of work of	one during m	nost of worki	ing	16b. I	Kind of Business	Industry
212	vithin jiene. er thau the N	ပ္ပြ	Elementary/Seconday (0-12)	College (1-4 or		life. DO NOT use ret CCOUNTING	,	WT SUB		MET	JSPAPER	
	filed val Hyg d othe	Be C	17. Father's Name (First, Middle, I	ast)		OCCUPITING			e (First, Middle			
yla	uld be I Ment narke natic e	₽	JOSEPH ADAMS					MARGA	RET GII	BER	Γ	
Maryland	2 shot th and th is n traum		19a. Informant's Name/Relations JOSEPH B. STAUB			. Mailing Address (Si				-		· ·
	f Heal f Heal item		20a. Method of Disposition		20b. Place of	Disposition (Name of	of	1		_	ocation - City or	
Baltimore,	permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me once.		1 ☐ Burial 2 🔀 Cremation 4 ☐ Donation 5 ☐ Other (S	3 ☐ Removal from State		y, crematory or othe DALE CREM		24, 2	EMBER 2011	NET	VARK, DE	LAWARE.
3alti	permit. Departn Importa any inju		21. Signature of trade Spories	ense	1						AL HOME,	
_	© 0 = @ 0		mulie (10 1 0 5						EAST, MA	RYLAND21901
ı	CONTRACT.		23a. Part 1. Enter the disease, shock, or heart failure. List of Immediate Cause (Final	nly one cause on each lin	a the death. Do r e.					irrest,		Approximate Interval Between Onset and Death
€	Pnysician/ Medical		disease or condition resulting in death)	a. Due to (or as	a consequence o	Breag	ST Cai	ncer				
Sant.	Examiner	L	Sequentially list conditions	h	,							
کران	D #	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence o	of):						
T	and l-trans	Exan	that initiated events resulting in death) Last	c. Due to (or as	a consequence o	of):	_					
0	cate be executed physician and s the burial-transit	edical Examiner		C _d								
68760			IF FEMALE:						•			
9 x	th cert	jan/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death						23d. Date of de Month	livery Day Year
Box	the a	Physician/M	1 ☐ Yes 2 🔀 No 9 ☐ Unknown	4 🗌 Pregnant a 9 🔲 Unknown	t time of death	5 Other (speci	fy)				WOUTH	Day real
P.O.	that the	by Pr	Part II. Other significant condition	ns contributing to death b	ut not resulting i	n the underlying caus	se given in Pa	art I.	23e. Did	tobacco	use contribute to	the cause of death?
ds,	quires en sig ould by								1 🗆	Yes 2	! □ No 3 □ F	robably 4 Unknown
cor	law rei as be	Completed								opsy	prior to	topsy findings available completion of cause of
Re	r. The		7						1 🗆 Yes	formed?	death?	s 2 No
/ital	sician certif irecto	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:	0 T FD/O	tpatient 3 ☐ DOA	6. Place of D		, , , , , , , , , , , , , , , , , , , ,		a 🗆 ou - 10	
Division of Vital Records,	g Phy er this heral d		27. Manner of Death	28a. Date of inju	ry 28b. T		Injury at		me 5 ∟ Hes 28d. Describe		6 Other <i>(Spec</i> ry occurred	city)
ion	tendin eath. or: Aff the fur	ifica	1 Natural 5 Pendin 2 Accident Investig 3 Suicide 6 Could	ation	, rear)	M M	work? 1 Yes 2	2 □ No				
Nisi	or Att after d Direct in by t	Certificate:	4 Homicide determ			m, street, factory, of	fice		28f. Location City or To			ral Route Number,
Ω	To the Hospital or Attending Physician: The law requires that the death certification 24 hours attendeath. To the Funeral Director. After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier 1 Certifying	Physician: To the best of	my knowledge,	death occured at the	time, date ar	ind place, an	d due to the c	ause(s) a	nd manner as st	ated.
	he Ho iin 24 I he Fu	Med	(Check 2 Medical E	xaminer: On the basis of e Nurse Practioner: To the	xamination and/o	r investigation, in my	opinion, death	h occurred at	the time, date	and plac	e, and due to the	cause(s) and manner stated.
	Vith vith Con		29b. Signature and title of certifier	1/2	A		cense numbe		<i>(</i> 2	29d. Da	ate signed (Mont	
	, ,		196	/			0006				1/22/	2011
	4		30. Name and address of person v SHAHNAWA Z SEP 2 7 2011	vno completed cause of d	eath (Item 23a) (UE HORM	AN Hn	UY, 501	TEA, CI	HESA	PEAKE CO	TY MD 21915
	Stat		31. Date filed (Monta, Day Year) SEP 2 7 2011	32. Registra	er's Signature	11	,	112-1		, , , ,		
	Registra	ar	254 % 1 5011	Clevera &	. gar							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month 09 Physician/ Agnes Spell 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Poninsula Regional Medical Center Salisbur Wicomico Year If Under 24 Hrs Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Funeral 438-52-5157 Days Director 72 1 □ M 2 🕱 F Yrs. 10/22/1938 Louisiana 28a-f show 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Funeral Director 1 Yes 2 X No Maryland Salisbury Wicomico 10e. Street and Number 23a or 10f. Zip Code 10g. Citizen of What Country? 27819 Pointers Lane 21801 USA "natural", or items Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates Yes 2 No Specify White 3 Widowed 4 X Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Cashier Food Chain Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ryley Spell Louise (unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27819 Pointers Lane, Salisbury, MD 21801 Michael McLaughlin/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Parsons Cemetery 9/21/2011 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses HOTTOWAY Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tra Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 9 Unknown g Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 death? 1 Yes 2 No Yes Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 2 No Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28c. Injury at work? 28a. Date of injury 28b. Time of Certificate: 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 24 hours after death. Funeral Director: A 1 Yes 2 No Investigation Accident the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 🗹 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year Month 8:57 P Patricia Ella Stevenson 201 Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. Gounty of Death Coastal Hospice at the Lake WICOMICO Salisbury 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country)
 MD 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 M 2 X F Min. **Director** 216-38-9716 28a-f show 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director notified MD Wicomico 1 Yes 2 No Salisbury r must be n 5 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 3682 Union Church Rd. 21804 USA items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. other traumatic event, the Medical Examiner Armed Force Black, White, etc. 5 þ 1 Never Married 2 X Married 1 ☐ Yes 2 🕱 No If Yes, Give 1 Yes 2 No Specify. "natural" Completed 3 Widowed 4 Divorced Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) than Elementary/Seconday (0-12) College (1-4 or 5+) alth and Mental Hygiene. Co-Owner Stevenson Trucking Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Page 1 and 2 should be Garland Pasquale Annonio Matilda Valentino 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Stevenson Jr. 3682 Union Church Rd. Salisbury MD 21804 3altimore, mportant; If item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 0 cemetery, crematory or other place any injury o Salisbury Crematory 09|21|2011|Salisbury Maryland 22. Name and Address of Facility Holloway Funeral Home P.A. 501 Snow Hill Rd Salisbury Md 21804 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death RRCTOSIGMOID Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Unuerlying Cause (Disease or linjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): ing physician a Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 - Fetal death in the past 12 months?
1 Yes 2 No Year Pregnant at time of death Month Day Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ₽ □ No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes (2 \(\) No certificate 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 Yes ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Il Director: After the Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural 1 Tes Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Funeral L Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier within 2 To the F 3- Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1802 WARE 150 31. Date filed (Month, Day, Year) SEP 22 Registrar's Sig State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Raquel Maria Santos 1323 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Wicomico Peninsula Regional Medical Conter Solisbur 8. Date of Birth (Month, Day, Year) **Funeral** If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Months **Director** 122-40-2353 1 □ M 2**X** F Guayaquil, Ecuador 84 -10 - 1927or 28a-f show Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 518 Elberta Avenue 21801 USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Spec.White Completed 3 🗌 Widowed 4 🗆 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Data Entry Operator Lever Bros. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Carlos Valencia Corina Chica 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Monica Cannon/Daughter 518 Elberta Ave, Salisbury, MD 21801 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Place of Disposition (value cometery, crematory or other place) Date 1 Durial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Cremation, 19/21/2011 Dover, DE Pennie Smith W. Isabella St. nature of Funeral Service Licensee Salisbury, Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on a chiling the complex of the cardiac shock, or heart failure. Approximate Immediate Cause (Final and Death Ph_sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Physician/Medical Examine cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events use as the burial-tran and Due to (or as a consequence of): resulting in death) Last attending physician Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No , the a hed fu g Unknown g Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has Director: After this certificate 1 Yes 2 No 1 Yes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 🗹 No Other: 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 27. Manner of Death . Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred Natural injury 5 Pending after death. 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral D

completely filled i 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signatu and title of certifier 2011 15 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Paulette

J.

Year 2 Brauer

CRNP

200

Civic Ave,

Salisbury, MD 21804

Thomas Patrick

11-07436 Sweeney P

11-07436 Sweener Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

nk Jak			\ State of Maryland / I				Menta	al Hygiene	20	11 32541
			1- For Stalle Registrar	Certific	ate of	Death		R	Reg. No.	11 32341
	nysici		Decedent's Name (First, Middle,Last)					Date of Dea Month	Day Year	3. Time of Death
ledical E	⇒xaıııı	ner	Thomas Patrick Sweeney 4a. Facility Name (if not institution, give street and number)		- 14	h City Taylor and		October 4	1, 2011	1240 hrs
			303 Fallston Boulevard		4	b. City, Town, or L Fallston	ocation of	Death	4c. County of Harford	f Death
Fu	neral		5. Social Security Number 6. Sex 7. Age (In yrs. last birt	hday)	If Under 1 Year	If Under	24Hrs. 8. Date of Bi	irth (MM/DD/YYYY)	9. Birthplace (State or
Dir	ector		220-80-1921 1XM 2□F	49	Yrs.	Months Days	Hours	Min. 07/13,	/1962	Foreign Maryland
			Usual Residence of Decedent		_	<u> </u>				
	м япу		10a. State 10b. County 10	c. City, Town	or Location	n				10d. Inside City Limits
land	28a-f show	ğ	MD Harford	Bel	Air					1 Yes 2 No
. Мал	r 28a	Director	10e. Street and Number			10f. Zip Code		1	10g. Citizen of Wha	at Country?
ith the	23a o notif		912 Sidehill Drive 11 Marital Status		40.146	21015			U.S.A.	
ath w	items	Funeral	1 Never Married 2 X Married Armed Forces?					n? (Specify Yes or No Puerto Rican, etc.)	0- 14, Race - White,	- American Indian, Black, , etc.
215-0036 Blow within 72 hours after death with the Maryland for the control of th	1", or		1 Yes 2 X	No	1	Yes 2X No	specify:		Specify:	White
ours a	sturs	d by	15. Decedent's Education (Specify only highest grade complete	eted) 16a, I		s Usual Occupation			16b. Kind of Bus	
6 72 h	than "n	ete	Elementary/Secondary (0-12) College (1-4 or 5+)		during mo	st of working life. [OO NOT us	se retired)		
MD 21215-0036 d 2 should be filed within 7 th and Mental Hunjers	neman riggiere. narked other than "narevent, the Medical Exa	Completed	12 6	1	Morto	jage Bank				ng Industry
filed	t, the		17. Father's Name (First, Middle, Last)					Name (First, Middle,		
212	marked ie event, t	o Be	Thomas Aguinas Sweeney 19a. Informant's Name/Relationship (Type, Print)	198	. Mailing	Address (Street :	Lelar and Number	Mae Gilb er or Rural Route Nur	ert mber City or Town	State Zin Code)
2 sho	27 is	-	Teresa M. Sweeney (wife)					- Bel Air		
i and	Important: If item 27 is mark injury or other traumatic even		20a. Method of Disposition	20b. Place o		ion (Name of ceme		Date	, 4	City or Town, State
TOP Pages	oth H		1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:			' '	Ca 1	10/10/2011	Timonia	m, Maryland
Baltimore, permit. Pages 1 an	porta ury o		gnature of Funeral Service Licensee	Durane	22. Na	me and Address o				eral Home, P.A
		_	ruther position	gradient -	1117	'50 Belai	r Roa	ad - Kings	ville. M	arvland 21087
Physi	ician dical		23a. Part I. Enter the discase, or complications that caused the failure. List only one cause on each line. Ethano1	death. Do no	t enter the	mode of dying, su	uch as card cardi	diac or respiratory am	est, shock, or hear	Approximate Interval Between Onset and
	niner	ı	Immediate Cause (Final disease a. by kypother	mia						Death
			or condition resulting in death) Due to (or as a consequ	ence of):						
		ē	Sequentially list conditions, if any, leading to immediate Due to for as a consequence of the conditions of the conditio	enes of):						
1		Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last Due to (or as a consequence).	onno ef):						
DD B	nd ransit		events resulting in death) Last Due to (or as a consequence of the con	erice ory.						
ě	ıysician and burial - transit	edical	▼ UNPENDED ☐ AMENDED 23a, 2	27,28a-	f,pe	г ше, g920	0 10-	17-11 sm		
Box 68760,	physi the bu		IF FEMALE: 23c. If yes, outcome of the state	of pregnancy					23d. Date of d	lelivery
certifi	e attending phy for use as the b	<u>a</u>	past 12 months?	2 e of death	\equiv	I death 3	_Ectopic p	regnancy	Month	Day Year
Box death	d for u	iysici	1 Yes 2 No 9 Unknown 9 Unknown	e or death 5	Othe	r (Specify)				
P.O. 1	aned by the		Part II. Other significant conditions contributing to death but	ut not resulting	in the un	derlying cause giv	en in Part I	I. 23e. Did to	obacco use contrib	ute to the cause of death?
S, P	as been signed t	ğ Ş						1 1 Yes	2 No 3	Prooably 4 V Unknown
v requ	s been should	Completed						24a, Was autop		ere autopsy findings available or to completion of cause of
Pe La	2 14	E						perfo	rmed? de	ath? ✓ Yes 2 No
E E	his certificate has t director, page 2 sh	Be C	25. Was case referred to medical examiner?					heck only one)		
' Vit	e p	<u></u>	1 ✓ Yes 2 No No No Inpatient		tpatient	0 0011		lursing Home 5		
ding]	After t funeral		27. Manner of Death 28a. Date of Injury (Month, Day, Year)	28b. T	ime of Inj		_	cubiact	how injury occurred exposed	
SiO Atten	ector: by the	cati	2 X Accident S Pending Investigation 1 28e. Place of Injury 28e. Place of Injury		2:35	Pш	s 2 x N	Lenation		BI.B. da Mb O'
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.	To the Funeral Director: completely filled in by the	Certification:	Suicide Could not be determined (Specify)			•	iding, etc.	or Town, S	tate) 303 Fa	Transport Route Number City
Hound 4	duner ely fill		29a. Certifier				and place	Fallsto	_	
o the 1	the I	Medical	one) 2 Medical Examiner: On the basis of examina							
To	E 93	Me	and manner stated, 29b. Signature and title of certifier	RAI		29c. License r	number		29d. Date signed	(Month, Day, Year)
			Tieto Watter feel	100		O.C.M.	E.		October 5, 2	2011
0			30. Name and address of person who completed cause of death			1				
Y	4		Victor Weedn MD JD Assistant Medical Ex	kaminer	900 W.	Baltimore Stre	eet, Balt	timore, MD 2122	23	
ľ		_	31. Date filed (Month_Day, Year) 32. Registrar's S							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of M	1 arylan				and M	lental Hy	giene	011	2251.2
		_	Registrar 1. Decedent's Name (First, Middle,	Last		Cer	tificate o	Death			Reg. NZ	UII	32542
н	Physicia		William	,		50.				2. Date of Dea Month	Day	Year	3. Time of Death
200	Medic Examin		4a. Facility Name (if not institution,	Paxson give street and number)		Sot	4b. City, Town	or Location		<u>October</u>		2011 County of Deat	10:10 A M
			106 S. Mulberr	y St.				stown	-1 2 0 0 0 1 7			Washing	
i	Funeral		· · · · · · · · · · · · · · · · · · ·	6. Sex 7. Ac 1 X M 2 □ F		ast birthday)	If Under 1 Year Months Day	ar If Under	24 Hrs. Min.	8. Date of Birt	h	9. Bir	thplace (State or Foreign
	Director		215-34-2821 Usual Residence of Decedent	I ALIWIZ LIF	74	Yrs.	Working , Bay	Tiodis	IVIIII.	(Month, Day Sept. 30	19	37 Was	hington DC
	and show	٥	10a. State 10b. County		10c. City	y, Town or Lo	cation						10d. Inside City Limits
	Manyla 28a-f	Director	MD Washin	gton	Has	gersto	vn						1 🛣 Yes 2 □ No
	a or 2	ig le	10e. Street and Number				10f. Zip Code)		Γ	10g. Citiz	en of What Co	ountry?
	th with ms 23 must	Funeral	106 S. Mulberr				2174				1	U.S.A.	
	r deat		11. Marital Status1 ☐ Never Married 2 【▼ Married	12. Was Decedent Armed Forces?		5. 13. V	Vas Decedent of Yes, specify Cu	f Hispanic Ori ıban, Mexicar	igin? (Spe n, Puerto l	cify Yes or No- Rican, etc.)	1	 Race - Ame Black, White 	
036	s afte ral", d Exan	ed by	3 Widowed 4 Divorced	1 ☐ Yes 2 X If Yes, Give Year or Dates,	No	1	☐ Yes 2【】	No Specify.	:		s	pecify: Wh:	ite
5-0	hour hatu dical	Completed	15. Decedent (Specify only highes	's Education			lent's Usual Occ					d of Business	
12	hin 72 ne. than '	om	Elementary/Seconday (0-12) Unknown	College (1-4 or	5+)	life. Do	aind of work don NOT use retire	e during mos ed)	I OF WORKI	ig	_		
D D	ed wit Hygie other	Be C	17. Father's Name (First, Middle, La	etl		Custo	odian	10 84046	awla Niama	Timb Ministra			Education
laŭ	be fill ental 'ked c	힏	Marvin T. Sours	,						(First, Middle, I		,	
Baltimore, Maryland 21215-0036	hould and M s mai		19a. Informant's Name/Relationship	o (Type, Print)	-	19b. Mailin	g Address (Stree						o Code)
Σ	nd 2 s ealth a n 27 i		Linda M. Sours/	Wife			• Mulbe						
ore	ie 1 au t of H If iten or oth		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3	Bemoval from State	20b. P	lace of Dispos	sition (Name of natory or other p			ate		ation - City or	
Ħ,	t. Pag tment rtant: ijury o		4 ☐ Donation 5 ☐ Other (Sp	ecify)	Smi		g Crema					hsburg	
Ba	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Lic	onsee			Name and Add						•
		-	23a. Part 1. Enter the disease, or c	omplications that cause	d the death		the mode of d				_	town,	MD 21742 Approximate
J	h sician/		shock, or heart failure. List on Immediate Cause (Final	y one chuse on each line	e. 12								Interval Between Onset and Death
	Medical		disease or condition resulting in death)	a. Due to (or as	a consequ	ie e of):	ng	17	in	RU			
	Examiner	_	Sequentially list conditions,	b ————		/n	na	CAR	cr	R			
	sit sit	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequ	ience of):	/						
	and and Il-tran	Exar	Cause (Disease or linjury that initiated events resulting in death) Last	c. Due to (or as	a consequ	ence of):							
09	certificate be executed nding physician and use as the burial-transii	dical		d									
9/89	ificate ig phy as the	Med	IF FEMALE:	_ u							ī		
Š	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live Birth			Ectopic pregna	ıncy			23	3d. Date of del	livery
Box	that the death ned by the atte e detached for	ysici	1 Yes 2 No 9 Unknown	4 ☐ Pregnant a 9 ☐ Unknown	t time of d		Other (specify)					Month	Day Year
J	at the	F.	Part II. Other significant condition	s contributing to death t	out not resu	ulting in the ur	nderlying cause	given in Part	l.	23e. Did to	bacco use	e contribute to	the cause of death?
<u>'S</u>	signe Id be	od by											robably 4 🔀 Unknown
o	w requ	olete								24a. Was a	n	24b. Were au	topsy findings available
Vital Records,	ding Pnysician: The law h. After this certificate has funeral director, page 2 %	Completed								autop: perfor 1 Yes	sy med? 2 No	death?	completion of cause of
<u>.</u>	ertifica		25. Was case referred to medical examiner?					Place of Deat	th <i>(Check</i>		2151 NO	1 163	2 L NO
>	this c	<u>ا</u> م	1 Yes 2 X No 27. Manner of Death			ER/Outpatient	3 🗆 DOA		ursing Hor	ne 5 🗶 Reside	ence 6	Other (Spec	ify)
ח סד	ding I	Certificate:	1 № Natural 5 Pending	28a. Date of inju (Month, Day		28b. Time of injury		ury at ork? □ Yes 2 □		8d. Describe ho	ow injury o	ccurred	
ois:	Atten r deat ctor: by the	¥	2 Accident Investiga 3 Suicide 6 Could no 4 Homicide determine	ot be	ury - At hor	me, farm, stre			-	8f Location (St	reet and I	Vumber or Ru	ral Route Number,
DIVISION	al Dire		4 - Hornicide determini	building, etc					- 1	City or Towr			a. 7.53.15 7.53.7125.,
	To the hospital or Attending Physician: The law requires within 24 hours after death. To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be	Medical	29a. Certifier 1 Certifying P (Check 2 Medical Exa	hysician: To the best of	my knowle	edge, death o	ocured at the tin	ne, date and p	place, and	due to the cau	se(s) and	manner as sta	ated. cause(s) and manner stated.
-	thin 2 the F		only one) 3 L Certifying N	drse Practioner: To the	best of my	knowledge, d	eath occurred at	the time, date	and place	, and due to the	cause(s) a	and manner as	stated.
·	2 <u>3 5</u> 8		29b. Signature and little of certifier	1	0	/		se number	710			signed (Month	
7		-	30 Name and address of person wh	no completed cause of d	eath (Item	23a) (Type Pr	int)	103	110			x T	2011
1	eV		Chuckia Brown		1	nedica	1 Cami	ous L	d H	lagersto	wn.	md a	2011
	State	_	31. Date filed (Month, Day, Year)	32. Red 5.		ure .			-30	1	- 11		
	Registra	r	OCT 12	2011 Dene	un	p. 4	arkel						

Amend #10fper F AACO Health Dept		se Type or Pri						•	_	ble.	
Also rearest expe	For State	State of Ma	aryland /		ment of F ficate of E		and Ment				00510
	Registrar 1. Decedent's Name (First, Middle,	Last)		Certii	icate of L	Jeaur	2. D	ate of Death	g. No2		3
Physician/ Medical	Cora Tyler						Ser	otemb	er 22	201	5:10P M
Examiner	4a. Facility Name (if not institution,			4	b. City, Town, or		of Death		4c. County of	of Death	
Funeral	Fairfield Nu		(In yrs. last bir	rthdav) 1	Crown f Under 1 Year	SVil		ate of Birth	Anne		undel
Director	579-30-8087 Usual Residence of Decedent	1 □ M 2 🔀 F			onths Days	Hours		Lyth, By1	^{'ea} 1923	Mar	1and
and show			10c. City, Tow	n or Locati	on					1	0d. Inside City Limits
he Marylanc or 28a-f sho i notified at Director	Maryland Anne	Arundel	Glen	Bur	nie						1 🗆 Yes 2 🕅 No
re, Maryland 21215-0036 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. The Barband Mental Hygiene. The Bear and Mental Hygiene. To Be Completed by Funeral Director	10e. Street and Number	_			10f. Zip Code	046		10	g. Citizen of W	hat Coun	try?
death with th items 23a o her must be Funeral I	674 Saint Geo	orge Ave	ver in U.S.	13. Was	-20 Decedent of Hi		061 -	es or No-	USA 14. Race	Americ	an Indian
fter de amine	1 Never Married 2 Marri	Armed Forces? ed 1 \(\sum \) Yes 2 \(\overline{\mathbb{X}} \) \(\text{1} \)					igin? (Specify Yen, Puerto Rican,	, etc.)		, White, e	
OUTS al ntural" al Exa	3X Widowed 4 □ Divorced	If Yes, Give Year or Dates.			Yes 2X No		:		Specify:	B1	ack
Baltimore, Maryland 21215-0036 Dearnit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hyglent amportant: If item 27 is marked other than "natural", on my injury or other traumatic event, the Medical Examinose. To Be Completed by	15. Deceden (Specify only highes	t grade completed)		(Give kind	's Usual Occupa f of work done d OT use retired)		t of working	1	6b. Kind of Bus	siness Inc	lustry
within giene giene her the It, the I	1 2 0 11	College (1-4 or 5+	+)		esser			1	Dry C1	ean	ing Co.
and and be filed vental Hyge ked other cevent,	17. Father's Name (First, Middle, La						er's Name (First,				
arylc ould b ould b nd Mer mark imatic	Richard H. Ed		100	h M-00- A	ddua (Ot 4 -		chel A			. ~ .	
Ma d 2 sh alth ar alth ar 27 is	Shirley Wilso						er or Rural Route Rd. Cr				. 21032
Ore, e1an of He if item	20a. Method of Disposition 1 X Burial 2 Cremation	2 Pamayal from State	20b. Place o		on (Name of ary or other place	e) -	Date	20	Oc. Location - C	City or To	wn, State
timor t. Page 1 tment of tant: If it	4 Donation 5 Other (Sp	ecify)	Mary	land	Veter	an	9-27-1				le, Md.
Baltimor permit. Page 1 Department of Important: If is any injury or o	21. Signature of Funeral Service Lie	censee O					Sons M		_		01.401
	23a. Part 1. Enter the disease, or o	complications that caused	the death. Do r				Dr. An			la.	Z 1 4 U 1 Approximate
Ph, sician/	shock, or heart failure. List or Immediate Cause (Final disease or condition	lly one cause on each line.	+	1		•		,			Interval Between Onset and Death
Medical Examiner	resulting in death)	a. Pue (or as a	consequence	of):	eum	nia				+	
	Sequentially list conditions,	b. — Durts (2000)		-0						_	
kecuted and al-transit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a	consequence	of):							
is 6	that initiated events resulting in death) Last	C Due to (or as a	consequence (of):						\neg	
O. Box 68760 at the death certificate be t by the attending physici stached for use as the bu Physician/Medica		d								+	
687 Sertific Inding page as	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o	f pregnancy						00 d D-4-	-6 -1 - 15	
Box 68760 death certificate b ne attending physi ed for use as the b sician/Medic	in the past 12 months? 1 ☐ Yes 2 ☑ No	1 Live Birth 2			topic pregnancy her (specify)	/			23d. Date Mont		ry Day Year
P.O. E that the connect by the electrache	g □ Unknown	g □ Unknown									
Records, P. The law requires tha rate has been signed page 2 should be do	Part II. Other significant condition	is contributing to death bu	t not resulting i	in the unde	rlying cause give	en in Part i	1. 25		_	-	e cause of death?
requires peen should	- Cherry							4a. Was an			sy findings available
lecc								autopsy	pri	ior to con	pletion of cause of
tal R cian; TI cian; TI cian; TB ector, pa	25. Was case referred to medical examiner?	1			26. Pla	ce of Deat	th (Check only o	Yes 2	No 1	Yes	2 L/No
hysici hysici this ce all direct	1 ☐ Yes 2 ☑ No		nt 2 🗆 ER/Ou	<u> </u>	□ DOA Othe	r: 4 2/Nu	ursing Home 5	Residenc	ce 6 🗆 Other	(Specify)	
n of ding F h. After t funera	27. Manner of Death 1 Natural 5 Pending			Time of njury	28c. Injury work?	•		escribe how	injury occurred	I	
Division of Vital Records, tal or Attending Physician: The law requires is after death. In Director: After this certificate has been signed in by the funeral director, page 2 should be a certificate: To Be Completed the	2 Accident Investiga 3 Suicide 6 Could not	ot be 28e. Place of Injury				Yes 2□		ocation (Stree	et and Number	or Rural I	Route Number,
Diving all Diving all Ce		building, etc.					Cit	ty or Town, S	State)		
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but Medical Certificate: To Be Completed by Physician/Medical	(Check 2 □ Medical Ex	Physician: To the best of maminer: On the basis of exa	amination and/o	or investigati	on, in my opinior	n, death oc	curred at the tim	ne, date and r	place, and due to	o the caus	se(s) and manner stated. I
To the vithin To the comple	only one) 3 L Certifying N 29b. Signature and title of certifier	lurse Practioner: To the be	est of my knowl	ieage, death	29c. License		and place, and o		use(s) and manr I. Date signed (i		
	> Seller	MD			238	958	3	9	123/0	2011	
2/11	30. Name and address of person wi	, 611	ath (Item 23a) (Type, Print)				0.3	en	1	1430.00
State		2. Registrar	s Signature	208	Craw	1/191	hway o	5W 1	Hen?	jum	ne MD21061
Registrar	31. Date filed (Month, Day, Year) SEP 2 7 20	11 Semus	s Signature	park.		\vee	/				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 18 2011 5:45P M Aware Turner Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3163 Arundel on the Bay Rd. Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Hours 212-14-3588 **Director** 1**X** M 2 □ F 99 \$ept 23 1911 Maryland Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Annapolis 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 3163 Arundel on the Bay Rd. 21403 USA 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Force by 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 Yes 2X No Specify. If Yes, Give Completed 3 Widowed 4 ☐ Divorced **Black** Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 6th 0 Caretaker Self Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ George Turner Matilda Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles A. Simms Sr(Son) P.O. Box 3621 Annapolis, Md. 21403 20a. Method of Disposition 20c. Location - City or Town, State ²Marylⁿangonyarional: ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 🛛 Othe Handrombment 9-23-11 Memorial Park Laurel, Md. 21. Signature of Funeral Service Licenses Miniame Redseof ReilitSons Mortuary, Lavry 1922 Forest Dr. Annapolis, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final Onset and Death Ph_sician/ disease or condition ENDO Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Industrial Examine Due to (or as a consequence of): burial-transi Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician I for use as the buria Physician/Medical certificate be Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Discount at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day ate has been signed by the a page 2 should be detached f 1 Yes 2 No 9 Unknown P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Hospital or Attending Physician; The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 and page 2. autopsy performed? Yes 2 No 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred injury X Natural 5 Pending Accident Investigation М 1 Yes 2 No Acciden
Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🛮 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 2 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 06-2011

State

MD

Annapoli Mol. 214

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Anthony 31. Date filed (Month, Day, Year)

27 201

DHMH 17 Rev 1/2001

Registrar

11	-07213	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

imothy Logan	Tho	mpson 1- For State Registrar	State o	of Marylar		artment of rtificate of	Health an Death	d Menta	al Hygiene	Reg. I	201		32548
Physici ledical Exam		1. Decedent's Name (Firs		GAN THO	MPSON				2. Date of Month Septe	of Death	y Year 4, 2011		Time of Death 2222 hrs
		4a. Facility Name (if not in 3379 Turkey Poi	stitution, give			1	b. City, Town, or North East	Location of			4c. County of C	Death	
Funeral Director		5. Social Security Number 214-31-4544	1 🔯	7 M 2 F	. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Day		Min	of Birth (N	M/DD/YYYY) 9 1990	Birthpla oreign T Countr	ace (State or ELKTON YMARYLAND
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	214-31-4544 Usual Residence of Dece 10a. State 10b. C MARYLAND 10e. Street and Number 3379 TURKEY 11. Marital Status 1 X Never Married 2 3 Widowed 4 15. Decedent's Education Elementary/Secondary 12 17. Father's Name (First, I SAMUEL J. 19a. Informant's Name/Re SAMUEL J. 19a. Informant's Name/Re SAMUEL J. 20a. Method of Disposition 1 X Burial 2 Cre 4 Departion 8 Of 21. Street Funer S 23a. Part I. Enter the disearch failure. List only one Immediate Cause (Final dor condition resulting in december 1)	Divorced IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII	ROAD 12. Was Deced Armed Ford Armed Ford 1 Yes 1 Yes, Give Year or Dates: 1 highest grade College (1-4) ON, SR. Print) SR./F Removal from the cause of th	dent Ever in Uzes? 2 X No completed) or 5+) ATHER 20b. In State sed the death	NORTH S. 13. Was If You are the control of the con	on EAST 10f. Zip Code 21901 s Decedent of Hises, specify Cubar Yes 2 No 's Usual Occupation of working life ITY CONT Address (Street TURKEY Pation (Name of cerer place) TUNITED CEMETER ame and Address SOUTH Me	panic Origin, Mexican, F specify: ion (Give kir DO NOT us ROL S. 18.Mother's CARO t and Number OINT netery, Y of Facility	IT (Specify Yes Puerto Rican, et Precial Indian of work done se retired) PECIALI Name (First, Minimum (First	or No- c.) 16 ST ddle, Maid ANTHO e Number ORTH ER 1 UNERA	Citizen of What NITED ST 14. Race - A White, e Specify: WF b. Kind of Busin CON Ien Surname) DNY City or Town, S EAST, M Ic. Location - City NORTH EA L HOME, H EAST,	Country's FATES American stc. HITE HESS/Indus State, Zip MARYI ty or Tow MARY MARY	A Inside City Limits Yes 2 XXNo S Indian, Black, State AND 2 1 90 1 Vn, State MARYLAND
Box 68760, c death certificate be executed the attending physician and of for use as the burial - transit	Physician/Medical Examiner	Sequentially list condition if any, leading to immedia case. First Underlying (Disease or injury that initievents resulting in death) UNPENDED IF FEMALE: 23b. Was decedent pregnapast 12 months?	e Du de	AMENDED 23c. If yes, out 1 Live birtt 4 Pregnan 9 Unknown	come of preg	nancy 2 Fet	al death 3 [er (Specify)	Ectopic p	regnancy		23d. Date of de Month	livery Day	Year
Records, P.O. The law requires that the icate has been signed by it page 2 should be detached.	Completed by Phy	Part II. Other significant of				esulting in the ur	nderlying cause g		24a.	Yes 2 Was an autopsy performed	24b. Wer prio deat	Probably e autops r to comp	cause of death? y 4 Unknown sy findings available bletion of cause of 2 No
/ital siclan: is certif lirector,	æ	25. Was case referred to n examiner?	Hos	spital: 1 Inc.	atient 2	ER/Outpatient		Othor: -	heck only one)	5 Res	idence 6 🗸	Other Sc	ene
	tion: To	1 Yes 2 N 27. Manner of Death Natural 5 Accident	Pending	28a. Date of (Month, Di Sep 24, 20	Injury	28b. Time of In	jury 28c, Injur	y at Work?	28d. Des		injury occurred	74101.00	310
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	2 Accident 3 Suicide 6 Homicide	Investigation Could not be determined	28e, Place of (Specify)		ome, farm, street	, factory, office b	uilding, etc.	or To	wn State			Route Number, City
To the Hosp within 24 ho To the Func completely f	Medical C		i Examiner: 0		examination a		ed at the time, da						iuse(s)
H 3 H 3	We	29b. Signature and title of		-/:			29c. License O.C.N		OGME		d. Date signed eptember 2:		
1		30. Name and address of p		•	•	23a) Examiner	00 W. Baltim					-, 2011	
St Regist	ate	31. Date filed (Month, Day, SEP 2 7 2			strar's Signatu			5.5 01100		, 2			
Regist	eГ	OFI W . F		Marine -	14. 19	10000							

			Pleas	e Type or Pri lend item 2 0 State of Ma	nt in B 0a per arvland	Black Ir	delible In 1920 10— artment of	k, Ensure 13-11 vt Health and	All Copie	s Are	Legib	le.	
			State Registrar				tificate of			Reg. 2		32547	1
	Physicia Medi		Decedent's Name (First, Middle, L	Tam Tam	es 7	Tallor	^	·	2. Date of De Month	eath Da	ž ž	3. Time of Death	
and de	Exami	ner	4a. Facility Name (if not institution, gi 12213 Malin Lane	9				or Location of Deat	th	P:	. County of I rince	George's	
	Funeral Director		064-42-3725	Sex 7. Age	e (In yrs. Ias 60	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		rth ay, <i>Year)</i> 7 , 1	950 N	Birthplace (State or Fore Country) New York	eign
	aryland a-f show fied at	Director	Usual Residence of Decedent	Coorgo! s	10c. City,	Town or Loc	eation Bow	ie			•	10d. Inside City Lim	
	ith the Ma 3a or 28a it be notif	ral Dire	10e. Street and Number 12213 Malin Lane				10f. Zip Code	20715		10g. Ci	tizen of Wha		NO
960	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ed by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E		l If	Vas Decedent of H	Hispanic Origin? (S an, Mexican, Puer	pecify Yes or No- to Rican, etc.)		14. Race - /	American Indian, Vhite, etc. White	_
Baltimore, Maryland 21215-0036	within 72 hou glene. er than "natu , the Medical	Completed	15. Decedent's (Specify only highest of Elementary/Seconday (0-12)		i+)	(Give k life. DC	ent's Usual Occu ind of work done O NOT use retired Feacher	during most of wo	rking	Pr	ince (ess Industry George's ublic School	.s
yland	d be filed Mental Hy arked oth	To Be	17. Father's Name (First, Middle, Last						me (First, Middle, Mary Spa		Surname)		
, Man	nd 2 shoul ealth and I m 27 is ma		19a. Informant's Name/Relationship Cynthia L. Tallo	, , , ,	i			and Number or Ru Lane, Boy				, Zip Code)	
imore	Page 1 arment of He tant: If iter		20a. Method of Disposition 1 Surial 2 Cremation 3 4 Donation 5 Other (Specific		cen	netery, crem	sition (Name of latory or other pla Cemetery		Date 26-2011	l .		y or Town, State ville, MD	
Ball	Departition Depart	(21. Sign three of Funer II Service Los	mercion	De		Name and Address	ess of Facility Be Crain Hwy	eall Fun y, Bowie			5_	
٠.,	Ph _y sician/	100	23a. Part 1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition	nplications that caused one cause on each line	the death.	900	r the mode of dyin		c or respiratory ar	rrest,		Approximate Interval Between Onset and Death	<u>م</u>
	Medical Examiner	_	resulting in death)	Due to (or as a	a consequer	nce of):						1 /2 46	
	e executed cian and ourial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events	Due to (or as a									
	ate be exe hysician a :he burial∹		resulting in death) Last	Due to (or as a	a consequer	nce of):							
Division of Vital Records, P.O. Box 68760	ne death certificate be ex. y the attending physician ched for use as the burial	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live Birth 14 ☐ Pregnant at 9 ☐ Unknown	2 🗌 Fetal d	death 3 🗌	Ectopic pregnan Other (specify)	су			23d. Date o Month	f delivery Day Year	
ls, P.O	uires that the dea n signed by the a uld be detached t	by	Part II. Other significant conditions	contributing to death bu	ut not result	ting in the ur	nderlying cause gi	ven in Part I.				e to the cause of death?	own
Record	The nospiral or Artending Prysician; The law requires that the thin 24 hours after death. The Funeral Director: After this certificate has been signed by the mpleted filled in by the funeral director, page 2 should be detached.	Completed							24a. Was auto perfo	psy ormed?	prior deat	e autopsy findings availab to completion of cause o h? Yes 2 🙀 No	
ta	cian; I ertifica ector, p	Be	25. Was case referred to medical examiner?	U				lace of Death (Che		24000	0	res 2 A NO	
Z Z	Physical directions	2	1 Yes 2 No	Hospital: 1 ☐ Inpatie		R/Outpatient	3 DOA Oth	4 ☐ Nursing I	Home 5 Resident			pecify)	_
ouc	naing ath. r: After e fune	icate	1 Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day,	Year)	injury	worl		28d. Describe I	now injur	y occurred		
Division	tal or Atters are all Directored in by the	Il Certificate:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined			e, farm, stre	et, factory, office		28f. Location (S City or Tov			Rural Route Number,	
	no me nospital or within 24 hours afte To the Funeral Dire completed filled in t	Medical	(Check 2 L Medical Exan	ysician: To the best of r niner: On the basis of ex rse Practioner: To the b	:amination a	nd/or investi	gation, in my opini	on, death occurred	at the time, date a	and place	, and due to	the cause(s) and manner s	tated.
, s	Nothi To th		29b. Signature and title of certifie	MD			29c. Licens	e number		29d. Da	te signed (M	onth, Day, Year)	
	56		30. Name and address (person who		eath (Item 23	3a) (Type, Pr	int)	Perkum	Sule 21	0 /	tango	15 MD 21401	
	Stat Registra	e ir	SEP 2 6 2011	32. Registrar	r's Signature		J						

11-06809 Charles Taylor

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Charles Taylor		State of Maryland / Department of Health and Mental Hygien 1-For State Registrar Certificate of Death	e 2011 3254
Physic Medical Exam		1) 1. Decedent's Name (First, Middle,Last) Charles Wilbur Taylor Mont	of Death 3. Time of Death
)		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Peninsula Regional Medical Center Salisbury	4c. County of Death Wicomico
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1. Age (In yrs. last birthday) 4.1 Yrs. 1. Age (In yrs. last birthday) Months Days Hours Min. 1. Age (In yrs. last birthday)	e of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign DELAWARE Country)
Maryland 28a-f show any 1 at once.	for	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits 1 Yes 2 No
ith the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number 10f. Zip Code 19956	10g. Citizen of What Country? America
r death wi	Funer	3 Wildowed 4 Divorced IITYes, Give Year 1 Yes 2 A No specify:	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Fleath and Mortal Hygiens. In an arrange Important: If item 27 is marked other than "matural", Important: If item 27 is marked other than "matural", Imjury or other traumatic event, the Medical Examiner.	Completed b		16b. Kind of Business/Industry Construction
1215-0 lbe filed vental Hygin reked other	Be Co	Stanley Dale Taylor JOAN MARIE	iddle, Maiden Surname) CARTER TAYLOR
MD 2. Id 2 should lith and M. In 27 is m.	욘	Diana watkins Taylor wile 3296/A Gordy Road Laus	rel, Delaware 19956
Baltimore, permit. Pages I ar Department of Hee Important: If ite:		4 Donation Protein Specify: Cemetery	011 Bethel, Delaware
		110000 11111X	al Home, Inc. ts Seaford, De. 19973
Physician /Medical xaminer		Part I der in Asease, or coyf lications that caused the death. Do not enter the mode of dying, such as cardiac or respirate failure. List only one cause of each line. Immediate Cause (Final disease a. Electrocution	ory arrest, shock, or heart Approximate Interval Between Onset and Death
	<u>.</u>	or condition resulting in death Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Due to (or as a consequence of):	
cuted nd transit	Examiner		
O, e be execu sician an	edical	UNPENDED AMENDED	
Acords, P.O. Box 68760, he law requires that the death certificate be executed ate has been signed by the attending physician and age 2 should be detached for use as the burial - transit	Physician/M	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23d. Date of delivery Month Day Year
P.O es that t	Ď		Did tobacco use contribute to the cause of death? Yes 2 ✓ No 3 Probably 4 Unknown
Division of Vital Records, at a Attending Physician: The law requires after death. al Director: After this certificate has been si led in by the funeral director, page 2 should be	Completed	24a.	Was an autopsy findings available prior to completion of cause of death? Yes 2 No 1 ✓ Yes 2 No
Vital Rehysician: The this certificate di director, page	B	25. Was case referred to medical 26. Place of Death (Check only one) examiner?	5 Residence 6 Other:
on of anding Ph. th. r: After the funeral	ion: To	27 Magaza di Darilli	cribe how injury occurred t electrocuted
Division To the Hospital or Attendir within 24 hours after death To the Funeral Director: A completely filled in by the fu	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) Outdoors 28e. Place of Injury - At home, farm, street, factory, office building, etc. or T 508 Mair	ation (Street and Number or Rural Route Number, City own, State) n Street, Mardela Springs, MD
Divis To the Hospital or A within 24 hours after C To the Emeral Direct completely filled in by	Medical (
		Afle Brasse G. M. O.C.M.E.	29d. Date signed (Month, Day, Year) September 10, 2011
20		30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD	21223
St	_		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Gladys Mildred Year Tolley Month Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death COASTAL HOSPICE ATTHE LAKE ALI5BU Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 220-01-7220 1 □ M 2 🕱 F Months Hours 01/05/191 100 **Director** Maryland Usual Residence of Decedent 28a-f show 10a. State 10h County 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits must be notified Delaware New Castle 1 X Yes 2 No Newark è 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? items 23a 19 Long Meadow Court 19711 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. of Health and Mental Hygiene. item 27 is marked other than "natural", or iter other traumatic event, the Medical Examiner. 14. Race - American Indian, Affiled Forces?
1 ☐ Yes 2 🔀 No If Yes, Give Armed Force Completed by Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 K No Specify: White 3 X Widowed 4 Divorced Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William Christopher Fields Mary Esther Murray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria Prettyman/Niece 19 Long Meadow Court, Newark, DE 19711 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 5 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Department of Important: If any injury or once. 4 Donation 5 Other (Specify) Shad Point Cemetery 9/29/2011 Salisbury, MD Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on e Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 attending ph I for use as th IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Fetal death in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav the e de Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. sinned 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an this certificate has autopsy performed? page ; funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA Hospice 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28c. Injury at work?
1 Yes 2 No Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After Natural 5 Pending 24 hours after death. Funeral Director: A L Accident the Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number. 4 - Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Contain Nurse Fractioner: The basis of my knowledge 3 and contained at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 To the F 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

3TC State

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month

EP

Year)

O Bu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WHM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 2011

			1 - For State Regist	trar		State of M	iaryiano		artment <i>tificate</i>			na IV	ientai Hy				0 2 0	00
	Physic	ian/			irst, Middle, Las				·····outo	0. 5.			2. Date of De				3. Time of	 Death
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-	Exam	iner	4a. Facility	·	, 0	Hospital			4b. City, T		ocation of over S		na	4	c. County of De		omery	,
	Funera		5. Social Se	curity Numb	per 6. Se		ge (In yrs. las	t birthday)	If Under		If Under 24 Hours	-	8. Date of Bir		9. 1	Birthpla	ce (State or	
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	land show d at	ρģ			b. County			Town or Loc	ation				00,00	, , , ,		100	. Inside Cit	
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	rith the 23a or st be r					lateres Dand			10f. Zip (20004			10g. C	Citizen of What	-		
	eath w	Funeral	11. Marital 5		VUY KAL	hryn Road 12. Was Decedent I	Ever in U.S.	13. V	Vas Decede	nt of Hisp	20904 panic Origin	n? (Spec	cify Yes or No-		14. Race - Ar	S.A		
21215-0036	filed within 72 hours after death with the Maryland tal Hygiene. 4 other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	1 Nev	ver Married	2 🗓 Married Divorced	Armed Forces? 1 ☐ Yes 2 🚨 If Yes, Give Year or Dates.	No	lf lf	Yes, specif	y Cuban,	Mexican, F	Puèrto F	Rican, etc.)		Black, Wh			
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	d 2 shou alth and 27 is m		1		Relationship (Ty) nathaya:										or Town, State, . arylano			
Baltimore,	ge 1 and 2 nt of Healt : If item 2 or other		20a. Method	of Disposit	ion	Removal from State	20b. Plac	e of Dispos	sition (Name atory or oth	of			ate	-	_ocation - City			
ţ	nit. Page partment contant injury or		4 □ Do	nation 5	Other (Specify)	Georg	ge Wa	shingt	ton C	cem 09	9/26	/2011	Ado	elphi,	Mari	yland	
Ba	permit. Page Department of Important: If any injury or once.		21. Signatur	e of Funeral	Service License	Same	9	22. 118	Name and	Address W Ha	of Facility UMPS h	Hine ire	es-Rina Ave.,	ldi Silv	Funero ver Spr	il H ing	ome, MD:	Inc. 20904
	death certificate be executed The attending physician and ed for use as the burial-transit The attending physician and the principle of the	Examiner	Immediate disease or disease or d	Cause (Final condition death) / list condition to immediate or injury devents	ons,	a. Sudder Due to (or as a Due to (or a) Du	n Card	ce of):			,					Q	terval Betw nset and Di NS TAN	eath
	death certif ne attending ed for use a	Physician/Medical		ast 12 mont 2 No	hs?	3c. If yes, outcome of Live Birth 1 Pregnant at 9 Unknown	2 Fetal de	eath 3 🔲	Ectopic pre Other (spec						23d. Date of o	lelivery Da	y Ye	ar
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ě	The law cate has	Con			to Thri	ve							autop perfor	rmed?	death?		etion of cau	use of
<u>I</u>	sician: The certificate irector, pag	Be c	25. Was case examiner		177	ospital;				26. Place Other:	of Death (Check c	only one)					
5	g Phys erthis neral di	e: To	27. Manner o	f Death		28a. Date of injury	nt 2 X ER/ y 28I	b. Time of		Injury at			e 5 Resid		Other (Spe	ecify)		
<u>0</u>	endin eath. or: Aft the fur	ficat	1 X Natu 2 Acci	dent _	Pending Investigation	(Month, Day,	Year)	injury	м	work?	s 2 🗆 No	- 1		on injui	y oodan ou			
DIVISION OF	or the Pospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certifica	al Certificate:	3 Suic 4 Hom		Could not be determined	28e. Place of Injur building, etc.		, farm, stree	t, factory, o	ffice		28	3f. Location (S City or Town		nd Number or R	ural Ro	ute Numbe	s .
1	the Host lin 24 ho the Fune upletely f.	Medical	29a. Certifier (Check only on	2 _ W	ledical Examine	cian: To the best of ner: On the basis of experitionary To the	amination and	d/or investig	ation in my	oninion (death occur	rrad at th	a time date ar	ad place	and due to the	calleat	s) and manr	ner stated.
Ė	To t		29b. Signatur		f certifier					cense nu	ımber			29d. Da	te signed (Mon	th, Day,	Year)	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - State Registra AMEND#200perFH, 9/22/11; MAW, MoCo Certificate of Death 2. Date of Death 3. Time of Death September Day 16, 2011 Physician/ 730 PM M Martin Wender Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Silver Spring 2904 North Leisure World Blvd #506 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min May 13, Yay, Yar 18 Cowew York 286-03-0782 93 1 🛚 M 2 🗆 F Director Usual Residence of Deceden 28a-f shov 10c. City, Town or Location 10d. Inside City Limits 10a, State notified at Funeral Director 1 ¥ Yes 2 □ No MD Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code must be 23a United States 2904 North Leisure World Blvd **#506** 20906 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces?

1 No Yes 2 No 4972
If Yes, Give Year or Dates. Black, White, etc. ò þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White "natural" Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) nd Mental Hygiene. marked other than College (1-4 or 5+) 5+ Elementary/Secondary (0-12) the Procurement Division Head Federal Government traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, ပ Ethel Gillman David Wender and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health 3916 Springarden Street Olney MD 20832 Naomi Miller – daughter other 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place)
Arlington National Cem. 1X Burial 2 ☐ Cremation 3 ☐ Removal from State injury or Department of Important: If any injury or once. Arlington, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Edward Sagel Funeral Direction Inc MD 20852 M01163 Approximate
Interval Between
Onset and Death
month Part 1. 5 the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. ediate Cause (Final Physician/ Cerebrovascular Disease disease or condition Medical resulting in death) **Examiner** 10 years Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) requires that the death certificate be executed Stroke that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year 1 Yes 2 g Unknown 2 No n signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 autopsy performed' Yes 2 X No To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 👿 Residence 6 Other (Specify) 1 ☐ Yes 2 🗓 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work 5 Pending 1 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar Warren D.

mo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31818

3305 North Leisure World Blvd Silver Spring MD 20906

Septeber 19.2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 32552 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dorwin Bruce Wile September 2011 05:32 AM 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 415 Badgers Lane Calvert Solomons Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours 1 3 M 2 D F 10/03/1930 Michigan 381-26-8965 80 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 H No Maryland Calvert Solomons 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 415 Badgers Lane 20688 United States 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. rmed Forces?

123 Yes 2 No Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates 1 Yes 2 W No Specify: 3 Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Captain United States Navv 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dorwin Harter Wile Ethel Mae Steig 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruby Jean Wile / Wife 415 Badgers Lane, Solomons, Maryland 20688 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 & Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metropolitan Crematory 09/27/2011 Alexandria, Virginia 22. Name and Address of Facility Rausch Funeral Home, P.A. P.O. Box 600, Lusby, MD 20657 Approximate Interval Between Onset and Death Melastatic Due to (or as a consequence of): Pylmona Due to (or as a consequence or): Diabelen Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Pregnant at time of death Month Day Year 2 No g Unknown

Physician/ Medical Examiner

injury or other traumatic

1 and 2 s f Health a item 27 i

permit. Page 1 a Department of H Important: If ite any injury or otl

Physician/

Medical

Director

Funeral

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Completed

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Examiner

Funeral

Director

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"natural", or items 23a or 28a-f sho

should be filed within 72 hours after death with the Maryland I and Mental Hygiene.
'is marked other than "natural", or items 23a or 28a-f shor raumatic event, the Merical Examiner must be notified at

Baltimore, Maryland 21215-0036

Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed and physician Physician/Medical signed by þ page 2 should be Completed has this certificate hours after death.

Ineral Director: After this certific
d filled in by the funeral director, Be Certificate: To

Division of Vital Records, P.O. Box 68760

21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. De not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performed 2 100 1 Yes Yes 2 WNo 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Nesidence 6 Other (Specify) 27. Manner of Death 28c. Injury at work? 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident Suicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number SUL

D50290

130 Hospital Road, Suite 300, Prince Frederick, MD 20678

September 27, 2011

15+1 State

within 24 hours a

Medical

Registrar

MD

MD

32. Registra

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

<u>Dhiren Hasmukh Shah</u>,

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien) Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) September 11,2011 1650 PM **Physician** -ee Wright Henry /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner Dorchester Cambrida General Hospita 8. Date of Birth (Month, Day, Year) 47 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 H 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 □ F Delaware 64 222-28-9659 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Funeral Director Dorcherster Cambridge Md. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21613 1631 Race Street 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ∏Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify Black Completed by 3 ☐ Widowed 4 ☐ Divorced 'natural', 16b. Kind of Business/Industry 16a Decedent's Usual Occupation event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Dorchester Elementary/Secondary (0-12) College (1-4or 5+) Community Center Bus Driver 12 should be filed wind Mental Hygier7 is marked other th 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Elizabeth Cannon Wright, Sr. Willie ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any Injury or other tra once. 21687 Hensley Rd., Seaford, De. 19973
e of Disposition (Name of Date 20c. Location - City or Town Mary Mc Cray / Mother
20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 09-19-11 Dover, Delaware Direct Crematöry 4 Donation 22. Name and Address of Facility Bennie Smith funeral Home 21. Signature of Funeral Service Licensee 437 Front St. Seaford, De. 19973 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Myocardia INFARCTION Acute HOUR disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner COTONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hypertendo be executed and Due to (or as a consequence of): burial physician the burial Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 Probably 4 Unknown 1.01 demie Completed 24b. Were autopsy findings available prior to completion of cause of death? Medica 24a. Was an cate has l autopsy performe estive certificate Cong 1 ☐ Yes 2 🗷 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 M ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred After 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Box 68760. P.O. Division of Vital Records. Hospital or Attending in 24 hours alter the Funeral Director: Af

To the F

State Registrar

Medical

Moth 31. Date filed (Mont

29b. Signature and title of certifie

29a, Certifier

(Check only one)

30. Name and address of person who completed cause of Seath (Item 23a) (Type, Print) MO ezek

and manner stated.

29c, License number

29d. Date signed (Month, Day, Year)

Preston

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		,	1 - For State Registrar		State of N	iaryian	•	rtment rtificate			-	Reg. No	2011	32	554
	Physici	an	1. Decedent's Name (First, M. Josef W. Wil		t)						2. Date of De Month 09-05-		y Yea	ır	e of Death
	/Medio		4a. Facility Name (If not insti		street and number	r)		4h. City. To	wn. or Loca	tion of Deat			. County of De		:10 PM
أمير	Exami	er	William Hill			,			ston				Talbot		
	Funeral Director		5. Social Security Number 214–36–9343	6. Se		ge (In yrs.	last birthday) Yrs.	If Under 1		nder 24 Hrs. urs Min.	8. Date of Bir (Month, Do			Birthplace (Sta Country)	te or Foreign
	D D		Usual Residence of Deceder								10				
	arylar show	7	10a. State 10b. Co	•			ry, Town or Lo	cation							e City Limits ∕es 2⊠No
	the M	ecto	MD 10e. Street and Number	Talbo	t		Easton	10f 7in 0	040			10a Cir	tizen of What		es zigno
	with 3a or	Funeral Director	7096 Magdale:	ne Ct				10f. Zip C	601				USA	Country	
	death ms 2;	nera	11. Marital Status	10 00	12. Was Deceden	t Ever in U.	S. 13. \			ic Origin? (S	pecify Yes or No o Rican, etc.)		14. Race - A	merican Indiar	١,
Maryland 21215-0036	in 72 hours after death with the Maryland "natural", or items 23a or 28a-f show ladical Examinat must be notified at	þ	1 ☐ Never Married 2 🔀 3 ☐ Widowed 4 🗍 Divo		Armed Forces 1 XYes 2 ☐ If Yes, Give Year or Dates:] No		fYes, specify I∐Yes 2 ∑		xican, Pueri ecify:	o Rican, etc.)		Black, WI		
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ary	shou and N s mar		19a. Informant's Name/Relat	ionship (7)	ype. Print)		19b. Mailin	g Address (S	Street and N	umber or Ri	ural Route Numb	er, City	or Town, State	e, Zip Code)	
	es 1 and 2 should b of Health and Ment f Item 27 is markec r other traumatic e	9	Maria Chris W	ilke	(Wife)					t PO I	3323 3ox	Ea	ston M	D 2160	1
Baltimore,	Pages 1 nent of H int: If Iter iry or oth	1	20a. Method of Disposition 1 🖾 Burial 2 ☐ Cremat 4 ☐ Donation 5 ☐ Othe			9 /	Place of Dispo emetery, cren			00.0	Date		ocation - City		?
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	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_	a	spir.	rtin	Fa	tun	onia	/			Oliset a	nd Death
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Records,	w require been signature should b	ed k									1 🗆	Yes 2	X No 3□	Probably 4	Unknown
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	lo the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical		cal Exami	sician: To the besi ner: On the basis and manners	of examina									se(s)
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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			Registrar 1. Decedent's Name (First, Middle, Last)	or timedia or Boutin	2. Date of Deat	
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a longer	Medic Examir		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
1	/		29661 DOVER ROAD	EASTON		TALBOT
	Funeral Director		5. Social Security Number 451-39-9384 6. Sex 1	Months Days Hours Min.	8. Date of Birth (Month, Day, 05–05–]	
	d tow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits
	arylan a-f sh fied a	Director				1 ☐ Yes 2 🛣 No
	or 28	<u>=</u>	MD TALBOT 10e. Street and Number	EASTON 10f. Zip Code	1 1	0g, Citizen of What Country?
	with t	Funeral	29661 DOVER ROAD	21601		UNITED STATES
	eath tems er mu	Ē	11. Marital Status 12. Was Decedent Ever in U.S. 13	3. Was Decedent of Hispanic Origin? (Spe	ecify Yes or No-	14. Race - American Indian,
21215-0036	n 72 hours after death with the Maryland 3. an "natural", or items 23a or 28a-f show Medical Examiner must be notified at	þ	1 ☐ Never Married 2 🕅 Married 3 ☐ Widowed 4 ☐ Divorced Armed Forces? 1 ☐ Yes 2 📆 No If Yes, Give Year or Dates.	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 👿 No Specify:	Rican, etc.)	Black, White, etc. Specify: WHITE
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121	e filed within 7 tal Hygiene. ed other than event, the Ma	O I	12 4	OWNER	- (First Adiabate A	RESTAURANT
Maryland	e de fal ≘	To B	17. Father's Name (First, Middle, Last) PAUL WALLACE	18. Mother's Nam	RON HITLI	
lan	shou and is n		WILD	ailing Address (Street and Number or Rura	al Route Number,	City or Town, State, Zip Code)
	1 and 2 of Health item 27 other tr		ELLEN ELIZABETH TROUTMAN-WALLACE	29661 DOVER ROAD.	1 -	
Baltimore,	Page 1 anent of Hant of Hant: If ite		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 20b. Place of Disposition 20b. Place of Disposition	sposition (Name of rematory or other place) KENTER 09–16	Date	20c. Location - City or Town, State
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Вох	e dear the at hed fo	ysic	1 Pregnant at time of death 5	5 Other (specify)		Worth Buy 1968
P.O.	To the Hospital or Attending Physician; The law requires that the death certificat within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending pt completed filled in by the funeral director, page 2 should be detached for use as the completed filled in by the funeral director, page 2.	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tob	pacco use contribute to the cause of death?
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Division of Vital Records,	l or At after d Direct I in by	Certificate:	4 Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Str City or Town	reet and Number or Rural Route Number, , State)
	spita hours neral	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, deat	th occured at the time, date and place, ar	nd due to the caus	se(s) and manner as stated.
	ne Hc n 24 ne Fu	Med	(Check 2 Medical Examiner: On the basis of examination and/or invonly one) 3 Certifying Nurse Practioner: To the best of my knowledge	estigation, in my opinion, death occurred at e, death occurred at the time, date and place	t the time, date and be, and due to the	d place, and due to the cause(s) and manner stated. cause(s) and manner as stated.
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			- oro MD	090511) <	9-14-11
			30. Name and address of person who completed cause of death (Item 23a) (Type	, Print)		
	15		JORGE H. ABREGO MD 598 CYNWOOD I 31. Date filed (Month, Day, Year) 32 Registrar's Signature	DR, STE. 104, FASTO	N, MD 21	601
	Stat Registra	•	31. Date filed (Month, Day, Year) 32. Registrar's Signature SEP 19 2011	Park		

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ 09 M Washington Sertember 1011 Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number 4c. County of Death **Examiner** Baltimore Baltmore Northwest Hospita If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth **Funeral** 1 □ M 2 👿 F Months Hours JUNE 6, PENNSYLVANIA 87 196-16-9736 **Director** Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 X Yes 2 □ No MARYLAND HARFORD **ABERDEEN** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2200 PERRYMAN STATION UNITED STATES 21001 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: BLACK If Yes, Give Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) PRODUCTION WORKER SHOE MANUFACTURE is marked other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental 2 SANFORD GILES JANNIE MILLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 MARIS G. TURNER, JR (SON) 3804 WILLOUGHBY BEACH ROAD, EDGEWOOD, MD 21040 other Baltimore, tem чраптенt of Ht Important: If iten any injury 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) TRINITY AME ZION CEM. 09/27/11 DELTA, PA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility LISA SCOTT FUNERAL HOME, Scott LEWIS STREET, HAVRE DE MD 21078 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or injury that initiated events resulting in death) Last and-tran Due to (or as a consequence of) burialphysician s the burial Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗆 Yes 2 💢 No 3 🗆 Probably 4 🗀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performe 1 Yes 2 No 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 은 this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural work? 5 Pending 2 🗌 No To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29d. Date signed (Month, Day, Year) 29b. Signature

State Registrar lan veel

31. Date filed (Month, Day,

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Randallstown MD 2112

person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 24. Month Physician/ Alice Emma Woodhull 2011 1143 September Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ceci1 Calvert Manor Healthcare Center Rising Sun If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth **Funeral** 7. Age (In yrs. last birthday) Feb. 21 Min Year) 1 □ M 2 🔯 F 199-16-4464 87 Pennsylvania Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 XYes 2 No Maryland Cecil Charlestown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 725 Water Street 21914 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify. Specify: White 3 X Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education Kind of Business Industry ir Lady of Lourdes Hospital (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12)
Twelve Years College (1-4 or 5+) Licensed Practical Nurse Camden, New Jersey 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) James H. Malloy Frances Whitmore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 08043 Gregory R. Woodhull (son) 5066 Main Street, Voorhees, New Jersey 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Charlestown Cemetery | 10/01/11 Charlestown, Maryland ^{22. Name and Address of Facility} Lee A. Patterson & Son Funeral Home, P Perryville, Maryland 21903-0766 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Schemic Heart disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner CONGESTIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed
 24 hours after cleath.
 Funeral Director: After this certificate has been signed by the attending physician and signed by the attending physician and d be detached for use as the burial-transit RENAL FAILURE Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1
Yes 2
No 3 Ectopic pregnancy Month Day Year 5 Other (specify) Pregnant at time of death 9 | Unknown 9 Unknowr Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy perform performed?

1 Yes 2 No 1 Yes 2 XNo 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 😰 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) Hospital 1 ☐ Yes 2 🗓 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending iniury Accident Investigation completed filled in by the Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 To the I only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Br. Node Doo 65733 9/27/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

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31. Date filed (Month, Day, Year,

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32. Registrar's Signature

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ELKTON, MD

STREET.

21921

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

18. Mother's Name (First, Middle, Maiden Surname) NORA TODD 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 517 WATSON ROAD, CENTREVILLE, MD 21617 20c. Location - City or Town, State EASTON, MD FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 Interval Between Onset and Death nonth 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? Drun K 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No Yes 26. Place of Death (Check only one) 4 Nursing Home 5 X Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 00 50291 person who completed cause of death (Item 23a) (Type, Print) railread Aug bolds BORD MD **ORIGINAL**

Reg. No.

, 1934

4c. County of Death **OUEEN ANNE'S**

10g. Citizen of What Country?

14. Race - American Indian.

WHITE

Black White etc.

USA

Specify:

16b. Kind of Business Industry

HOSPITALITY

4:39

9. Birthplace (State or Foreign

10d. Inside City Limits

1 ☐ Yes 2 🔀 No

MARYLAND

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Registrar DHMH 17 Rev 7/2009

State

only one)

30. Name and address of

31. Date filed (Month, Day,

29b. Signature and title of certifier

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 15, Year 15, 2011 Frank T. Yost 13:57 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City Town or Location of Death 4c. County of Death Bowie Health Center Prince George's Bowie Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 🗆 M 2 🗆 F Days Hours May 30,1929 Months 176-22-8004 82 Yrs Pennsylvania Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b County 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Bowie Prince George's MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20715 12407 Melling Lane USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: er than "natural", the Medical Exa White 3 ₩Widowed 4 □ Divorced Korean Specify: Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) should be filed within and Mental Hygiene U.S. Government 4 Patent Examiner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Alice Thatcher Joseph J. Yost other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health an Important: If item 27 is any injury or other trau 6440 Cotswold Way, Broad Run, VA 20137 Erich Yost/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 9/20/2011 Baltimore, Maryland Metro Crematory 4 Qonation 5 Other (Specify) 21. Signatury of Funeral Syrvice License 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy, Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate O et and Death Immediate Cause (Final Physician/ Artery Disease oronary disease or condition VYars Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed and -tran: that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Year Pregnant at time of death 2 No 9 Unknown Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Prostate Cancer 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Gland Cancer Salivary Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy page 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical æ director 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital: မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, this nours after death.

neral Director: After this filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a

To the Funeral E

completed filled i Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of pertifier September 19, 2011 D50343 MD

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Registrar

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31. Date filed (Month, Da

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14999 Health Center Orne, Suite 201

Boure, Maryland 20716

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

MD

SEP 2 6 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Leonard Michael ZANDEL September 19, 2011 9:47 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Bethesda Suburban Hospital If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 X M 2 □ F NoV. 24, Year) 938 Months Days Hours New Jersey Director 139-32-0770 Usual Residence of Decedent 28a-f show 10a. State 10b. County Director 10c. City, Town or Location 10d Inside City Limits be notified 1 X Yes 2 No DC Washington 0 10e. Street and Number 10f. Zip Code ,s 23a o, r must br 10g. Citizen of What Country? Funeral United States 20015 3940 McKinley Street, NW 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 X Yes 2 No be filed within 72 hours after de ental Hygiene. 'ked other than "natural", or it ic event, the Medical Examine Black White etc. 'natural", or þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 Yes 2 No Specify 3 Widowed 4 Divorced Specify: white Completed Year or Dates, 1960's 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry
National Security (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Agency 5+ Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 27 is marked or traumatic eve and Mental ပ Miriam Stiller Irvin Zandel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15 Health tem 27 Gail Zandel, Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 09/25/11 20c. Location - City or Town, State Department of H
Important: If ite
any injury or ott 1 Surial 2 Cremation 3 Removal from State Garden of Remembrance Memorial Park Clarksburg, MD ☐ Donation 5 ☐ Other (Specify) f F reral Service Lic nsee Torchinsky Hebrew Funeral Home 20012 08254 Carroll St., NW, Washington, DC 23a. Part 1. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Congestive Heart Failure Medical **Examiner** 2 Weeks Myocardial Infarction Sequentially list conditions, if any, eaching to immodate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last 1 20 Years Coronary Artery Disease and Due to (or as a consequence of) the a ending physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Yes 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Records, 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 X No Vital or Attending Physician: after death. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 X No 욘 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ō 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at within 24 hours after death.

To the Funeral Director: After a completed filled in by the funer. 28d. Describe how injury occurred 1 Natural 5 Pending injury Division 1 ☐ Yes 2 ☐ No Accident
Suicide
Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier ី Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) 201 41520 September 21, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

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Mark Milner, M.D., 6410 Rockledge Drive, Suite 200, Bethesda, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 12 per fh g 920 10-19-11 yt
State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month William Albert Zentgraft, Sr. Sept M 20 11:40 P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 4155 Hallowing Point Road Prince Frederick Calvert 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min Feb 15 1936 217-34-2295 75 **Director** Maryland Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. It item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Maryland Calvert. Prince Frederick 1 Yes 2 X No 10e. Street and Number ral", or items 23a or Examiner must be n 10f. Zip Code 10g. Citizen of What Country? 4155 Hallowing Point Road Funeral 20678 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: white Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) public school/ agriculture school bus contractor/ farmer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be f Department of Heath and Mental Important: If item 27 is marked any injury or other traumatic ev once, Albert Zentgraft ၉ Thelma Hutchins 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4155 Hallowing Point Road Prince Frederick MD 20678 Genevieve A. Zentgraft-daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Cerit al Cerie Cerit (Cerie Cerit al Cerie 1 X Burial 2 Cremation 3 Removal from State Barstow Maryland 09/24/2011 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euperal Service Licensee 22. Name and Address of Facility Rausch Funeral Home PA 4405 Broomes Island Rd. Port Republic MD 20676 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph_sician/ sta disease or condition Medical resulting in death) Due to (or as a consequence of Examiner 6 month Sequentially list conditions, it any reading to in madelat cause. Enter Underlying Examine Directo for as a consecution of attending physician and I for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day Pregnant at time of death
Unknown been signed by the a should be detached t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown . Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? after death.

Director: After this certificate ☐ Yes 2 🗷 2 No filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be 2 Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a Medical 1-Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check Cartifying Nurse Practioner: To the best of my knowle 29b. Signature and title of certifier 29d. Date signed (Mon Day, Year) alum D0027189 9 21 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Zahir Yousaf, M.D. Huntingtown Maryland 20639

Registrar

31. Date filed (Month, Day, Year)

SEP 22 2011

acke

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 32562 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** Detaher 8:00 A M 2011 Katherine Arrington /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death NA Roland Park Retirement Place Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 0 1 - 1 2 - 2 3 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 K F 185-20-6568 88 Director NC Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits show r 28a-f sh notified M\ Yes 2 □ No Director MD Baltimore NA 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code mit. Pages 1 and 2 should be filed within 72 hours after death with sartment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or injury or other traumatic event, the Medical Examiner must be n 40th Street 830 W. 21211 USA by Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. African 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: American ¾ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Data Entry T.B.S. Company 12th Grade 4yrs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cornelius W. Jenkins Catherine Bratton ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau once. 1056 W. Fayette Avenue Baltimore, MD 21223 William H. Gunn, Jr.-Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 10-13-11 Catonsville, MD Metro Crematory 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Augitatu clear **Physician** unive YEARS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) certificate be executed and burial-tran Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical the IF FEMALE nse If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy perform 1 ☐ Yes 2 ☑ No Division or Vital Physiclan: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 🗀 Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 27. Mann of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending (Month, Day Year) 1 Natural 5 Pending investigation hours after death. 2 Accident 1 ☐ Yes 2 ☐ No 24 hours after death e Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ determined 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Mas greger 57) 013657 > 17 Teahelle October 12,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
17. IS ABELLE TALEGREFOR, 700 W FOTH STREET, BALTITORE, 17021211 M. ISABELLE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registra OCT 1 3 2011

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	State of Maryland	Department of He	alth and Mer	ntal Hygiene

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		1- For State Registrar	Ce	rtificate of L	Death		, 0	Reg. No.		
Physic		Decedent's Name (First, Middle, La	·				2. Date of D Month		3. Time of Death	
Medical Exam	iinei	Saleem N. Abdullah 4a. Facility Name (if not institution, give street and number)			4b. City, Town, or Location of Death			ber 22, 2011	2112 nrs	
		Western Maryland Medic	·		. City, Town, Cumberla		eath	4c. County o Allegany		
Funera Director		5. Social Security Number unk 6. S	Sex 7. Age (In yrs.	last birthday) 53 Yrs.	If Under 1 You Months Da				9. Birthplace (State or Unk Foreign Country)	
		Usual Residence of Decedent		TIS.			12-8		Godiniy)	
hours after death with the Maryland "natural", or items 23a or 28a-f show any Examiner must be notified at once.	Funeral Director	10a. State 10b. County	10c. City	, Town or Location					10d. Inside City Limits	
		MD Allega	iny	Cumber1	and				1 Yes 2 No	
		13800 McMulle	n Hgwy SW	1	10f. Zip Code	21502		10g. Citizen of Wh USA	at Country?	
death with or items 2.		11. Marital Status unk 1 Never Married 2 Marrie	12. Was Decedent Ever in U Armed Forces? 1 Yes 2 No			Hispanic Origin? (an, Mexican, Pue		No- 14. Race White	- American Indian, Black, , etc.	
s after ral",	₹		d If Yes, Give Year or Dates:		es 2XN				white	
36 hin 72 than	Completed	15. Decedent's Education (Specify of Elementary/Secondary (0-12) unk	College (1-4 or 5+)	16a. Decedent's during most	Usual Occup t of working li	eation (Give kind fe. DO NOT use	of work done un	1k 16b. Kind of Bus	siness/Industry unk	
STE, MD 21215-0036 as 1 and 2 should be filed within 7 of Health and Mental Hygiene. If item 27 is marked other than her fraumatic event, the Medical her fraumatic event, the Medical		17. Father's Name (First, Middle, Las		1	unk	18.Mother's Na	me (First, Middle	, Maiden Surname)	unk	
2121 Ild be f Mental marke event,	o Be	19a. Informant's Name/Relationship (Type Print \	10h Mailing A	ddraee (Chr.	act and Number	n Divisi Davis N	umber, City or Town	Olate 7: Only	
MD d 2 shoulth and 1 is 127 is 1	-	O.C.M.E.	Typo, Time y					ltimore,		
re, rand Thealth		20a. Method of Disposition		Place of Dispositio	n (Name of c		Date		City or Town, State	
Pages nent of ant: I	6	1 Burial 2 Cremation 3 4 Donation 5 X Other Specify	Tromoval nom otate	orematory or other	place	- 1		J.		
Baltimore, permit. Pages 1 at Department of Hee Important: If ite injury or other tr		21. Signature of Funeral Benvice Lice	Wade, Directo	or ²² SNag	etapd Addre	-		W. Baltin	more Street	
Physician		23a. Part I. Enter the Iseas , or com	plications that caused the death	Bal	timore		1201	rrest shock or hea	rt Approximate Interval	
/Medical Examiner		fulure. List only one cause on e	ach line. Asphyxia Due to (or as a consequence o		mode of dying	g, 50011 a5 501 a1a	o or respiratory a	most, shock, or heal	Between Onset and Death	
		Sequentially list conditions, b		.,,						
	ılne	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence of):						
sit sd	Examiner	(Disease or injury that initiated events resulting in death) Last Use to (or as a consequence of):								
executed in and il - transit		d. UNPENDED AMENDED								
760, Icate be execut g physician and the burial - tra	/Medical	IF FEMALE:	23c. If yes, outcome of pregr	nancy	<u> </u>		_	23d. Date of d	Helivopy	
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transi	Physician/	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live birth 4 Pregnant at time of de	2 Fetal o	death 3 (Specify)	Ectopic preg	nancy	Month	Day Year	
D. B t the d by the		Part II. Other significant conditions		esulting in the unde	erlying cause	given in Part I.	23e. Did	tobacco use contrib	ute to the cause of death?	
P.O. res that till signed by be detacl	d b						1 🗌 Y	es 2 🗸 No 3	Probably 4 Unknown	
of Vital Records, ng Physician: The law require the this certificate has been si nneral director, page 2 should b	Completed	-				_	24a. Was auto	ppsy pri ormed? de	ere autopsy findings available ior to completion of cause of ath?	
		25. Was case referred to medical			26.Plac	e of Death (Chec	1 Yes	2 No 1	Yes 2 No	
Vitis ce	To Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3	DOA	Other Nurs	sing Home 5	Residence 6	Other:	
After After funera	Ë	27. Manner of Death	28a. Date of Injury (Month, Day, Year) FOUND:	28b. Time of Injury		ury at Work?	28d. Describe Subject as:	how injury occurred	d	
Sior Attend death death oy the	catio	2 Accident S Pending Investigati	on Sep 22, 2011	2025 hrs		Yes 2 ✔ No				
Division of Vital To the Hopital or Attending Physician: within 24 hours after deturn. After this certifi To the Funeral Director: After this certifi completely filled in by the funeral director,	Certification:	3 Suicide 6 Could not determine		ome, farm, street, fa	ctory, office building, etc. 28f. Location (Street and Nor Town, State) Western Correctional Ir			State)	or Rural Route Number, City on, Cumberland, MD	
To the Hos within 24 h To the Fun completely	To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)									
To con	Me	and manner stated. 29b. Signature and title of certifier				29c. License number		29d. Date signed (Month, Day, Year)		
		S-70-		O.C.M.E.			September 23, 2011		23, 2011	
	Ì	30. Name and address of person who completed cause of death (Item 23a)								
- 4	1		Assistant Medical Exam		Baltimore	Street, Balt	imore, MD 2	1223	0	
St Regist		31. Date filed (Month, Day, Year) OCT 1 3 20:	32 Registrar's Signatu							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 28, **Physician** 2011 Henry Laurence Amon September 7:55 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4620 Potomac Road Pasadena Anne Arundel 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1√2 M 2□ F Months Days Hours Min. Director 221-28-3460 1947 28, Mary Land Dec 63 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, in Medical Exercites managed. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 No Director Pasadena Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4620 Potomac Road Funeral 21122 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 K No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ∏Yes 2X If Yes, Give Year or Dates: 1 Never Married Married 1 ☐ Yes 2 No Specify: white ģ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) automotive unk unk technician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mildred Vingina Stidham Henry Joseph Amon 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7822 Woodside Terrace #203 Glen Burnie, MD 21061 Bonnie Lee Amon/spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c Location - City or Town State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature 1 Funeral Structural d ²² Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Baltimore, MD 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lin Approximate Interval Between Onset and Death Immediate Cause (Final Mu Physician vers disease or condition resulting in death) Due to (or as a nsequence of) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence oi) burial-trai Due to (or as a consequence of) Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnapt 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 mont Month Year Day 1 ☐Yes 2 ☑ No 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □Yes 2 1 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 ₩No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 □Yes 2 □No 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

P.O. Box 68760. Division of Vital Records,

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed attending p signed by the a has To the Hospital or Attending Physiclan: Within 24 hours after death.

To the Funeral Director: After this certifica

filled in by the completely

State

Registrar

Medical

29a. Certifier

0

(Check only

29b. Signature and title of certifier

1 🕖 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

30. Name and address of person who completed

OSE Ritch'e Highway

31. Date filed (Month, Day, Year) 3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First Middle Last) 2. Date of Death Physician/ October 11 2011 James Albert Be11 7:30P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Greater Baltimore Medical Cente Towson Social Security Number If Under 1 Year | If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days Hours ine 23,1942 1 🕅 M 2 □ F Director 286-38-7983 69 Jun<u>e</u> Ohio Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director Marvland Baltimore Towson 1 ☐ Yes 2 🂢 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 803 Scarlett Drive 21286 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Force "natural", or Completed by Black, White, etc. 1 Never Married 2 Married 1 Yes 2 X No 1 ☐ Yes 2 ▼ No Specify: 3 ⅓ Widowed 4 ☐ Divorced Specify White Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. 5+ Pharmacologist Research Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ Frank Edward Be 11 Faulkner Artilissa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S 27 Richard Louis Bell / Son 5153 Terrace Dr., Nottingham, Maryland 21236 mportant: If item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ō 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place, injury or Metro Crematory Inc. 10/13/2011 | Baltimore, Maryland Taylor 21. Signature of Funeral Service LicenseeAlyson K 22. Name and Address of Facility Cremation Society of Maryland 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to for as a consequence of burial-tran Due to (or as a consequence of) resulting in death) Last physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Li Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) 1 ☐ Live Birth
4 ☐ Pregnant a
9 ☐ Unknown for in the past 12 months? Month Pregnant at time of death Dav Year 2 No ed by the a 9 Unknown After this certificate has been signed by funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy Failure death? perforn Director: After this certificate ! Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 7 24 hours after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical

DHMH 17 Rev 7/2009

State Registrar 29a. Certifier

(Check

29b. Signature and title of certifier

Cortifying Nurse Practioner To the best of my knowledge, deeth commi

pleted cause of death (Item 23a)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

6535 N.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

MD 2126

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 32566 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 4.38 PM Elizabeth Loone 20 Year Octobse Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death 5/2 Hospital Ihm 1Sa Itmuke Cita Social Security Number 219 · 30 · 795 Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Hours Director 1 □ M 2 🔀 F 11935 MD 08/30 28a-f show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location Be Completed by Funeral Director 10d. Inside City Limits Baltimore MD Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Windsor Garden Lane Apt. 2084 USA 21207 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working Florence Crittenton life. DO NOT use retired) Elementary/Secondary (0-12)

4th crade College (1-4 or 5+) ttome Housekeeper NIA ather's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Webb 19a. Info ant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Reed 3806 Glan Avenue Battimore MD 21215 (Daughter) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Baltinnone, MD Arbutus Memorial 10 15 2011 4 ☐ Donation 5 ☐ Other (Specify) Vaulty C. greene teneral services 22. Name and Address of Facility Road Pandallstown MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Onset and Death SystL Ph_sician/ disease or condition day Medical resulting in death) Due to (or as a consequence of): Examiner 10600013 Sequentially list conditions, Due to (or as a consequent of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Exami been signed by the attending physician and should be detached for use as the burial-transi Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Day 1 Yes 2 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy the Funeral Director: After this certificate In pletely filled in by the funeral director, pag 2 No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Tes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signatale and title of certifie 148732 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 V 31. Date filed (Month, Day,

Registrar

3 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Eddie Leroy Berry, Jr. 1 0 Month 2011 1.25 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Baltimore 4c. County of Death N/A**Examiner** Good Sam. Hospital Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign Days 1 🛛 M 2 🗆 F Months Hours 217-58-9128 60 (Month, Day, Year 6/29/51 Country)
MD **Director** Yrs Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at one. 10a. State 10b. Count 10c. City, Town or Location Baltimore **Funeral Director** 10d. Inside City Limits N/A MD 1 Yes 2 ☐ No 10f. Zip Code 21212 10e. Street and Number 10g. Citizen of What Country? 4535 St. Georges Ave USA 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1 ☐ Yes 2 ☐ No Black, White, etc. African Specify: Amer. ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give 3 🗌 Widowed 4 🗆 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed, (Give kind of work done during most of working Bank of America life. DO NOT use retired)
Customer Service College (1-4 or 5+) Elementary/Seconday (0-12) Be 17. Father's Name (First, Middle, Last) Eddie Leroy Berry, Sr. 8. Mother's Name (First, Middle, Maiden Surname)
Mare A. Anderson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4535 St. Georges Ave Polt Mp. 24242 19a. Informant's Name/Relationship (Type, Print) Shawn A. Berry/Wife Georges Ave, Balt., MD 21212 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 remation 3 Removal from State Balt., MD 10/12/11 Bayview Crem. 4 Donation 5 Other (Specify) Signature of Fune al Service Lix see 22. Name and Address of Facility Hari P. Close FSVs PA 5126 Belair Rd, Balt., MD 21206-5105 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Ph sician/ Acute W 10 cardia disease or condition resulting in death) 60 MIMS Medical Due to (or as a consequence Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Due to (or as a consequente of) red by the attending physician and detached for use as the burial-transit Cause (Disease or iinjury The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Dav Year 1 ☐ Yes 2 ☐ Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe ☐ Yes 2 X No 1 Yes 2 No the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 X No မ 1 🗌 Yes Other: 1 Minpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 XNatural 5 Pending 1 Yes 2 🗌 No Accident Investigation within 24 hours after death To the Funeral Director. 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature a 29c. License numbe 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

t Zun

3 2011

31. Date filed (Month, Day, Year)

0066394

LOC

plvd

Good Sangritan Hospital, 5601

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ George R. Bethea, Sr. Month 9 2011 ea 1:38p M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 2808 Rona Road Baltimore N/A ocial Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last hirthday) 8. Date of Birth (Month, Day, **Funeral** 9. Birthplace (State or Foreign Days Hours 219-52-8572 63 Country MD **Director** 1 XM 2 □ F 9/20/48 Usual Residence of Decedent 28a-f shov 10a. State with the Maryland must be notified at . County N/A 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Yes 2 No 10e. Street and Number o 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 2808 Rona Road 21207 USA "natural", or items within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Yes 2 No Yes, Give African Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: Completed 3 ☐ Widowed 4 ☐ Divorced Year or Dates Amer. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me Food Elementary/Secondary (0-12) College (1-4 or 5+) Manager permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other-any injury or other traumatic event, till once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Dorothy B. Baker Clyde E. Bethea, 19a. Informant's Name/Relationship (Type, Print)
Bessie L. Bethea/Wife 196 Maijing Address (Street and Number of Rural Route Number City of Town, State, Zip Code) 2808 Rona Rd, Balt., MD 21207 Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Balt. Cty, MD 10/15/11 King Mem Pk 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 1 Other (Specify 21. Signature of Fune at Service Lir ensee 22. Name and Address of Facility Hari P. Close 5126 Belair Rd, Balt., MD 21266-5105 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph_sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Physician/Medical Examine Due to (or as a consequence or) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innerial director, page 2 should be detached for use as the burial-transi Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Dav Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 ☐ Unknown No 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 1 Yes 2 No Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only of Hospital Other: မြ 1 🗌 Yes 2 l No 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? Natural 28d. Describe how injury occurred (Month, Day, Year) 5 Pending M 1 Yes 2 No Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signa 201 who completed cause of death (Item 23a) (Type, Print) Tree#135 Beltmore Marylon

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #15,17,18,20a-c &22 Per FH G920 10/13/2011 JH State of Maryland Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Ö 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Northwest Hospital/Seasons Hospice Randallstown Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Mar 7, **Funeral** 9. Birthplace (State or Foreign Black Maryland 217-66-1568 Director 1955 56 Mar Usual Residence of Decedent items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Tyes 2 No Fort Washington Prince George's MD 10e. Street and Number 10g. Citizen of What Country? Funeral 20744 USA 6900 Bock Road 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or in any injury or other traumatic event, the Medical Examin once. Completed by 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 2 💢 No black 1 ☐ Yes 2 X No Specify 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) llth healthcare home health aide Be 1111 K 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Gerald Frost Dolorese Greene 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
55 Wade Avenue Baltimore, MD 21228 Allen Graham/friend 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2XXCremation 3 Removal from Stat Final Journey 10/12/2011 Woodbine.MD 4 Donation 5 Y Other (Specify) Funeral Service License (a. . Baltimore St 700 Edmondson 1timore MD 21 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Immediate Ocuse (Final disease or contion resulting in death) Onset and Death Physician/ Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate
Cause (Disease or linjury Due to (or as a consequence of): ettending physician and or use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Month Dav Year signed by the a g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has a completed filled in by the funeral director, page 2 of the funeral director. autopsy performed Yes 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: 1 Tyes ည 4 Nursing Home 5 Residence 6 Other 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 5 Pending 1 🗌 Yes Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signat 29c. License number 08 MD 2/209 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month George B. Bisset, Jr. 2011 <u>October</u> 7:40 Medical 10 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Manor Care Potomac <u>Potomac</u> Montgomery Social Security Number If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Min Days Hours 579-26-1184 Country) **Director** 1 🗙 M 2 □ F 85 June 9, 1926 Washington, D.C permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he nextendence. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9905 Inglemere Drive 20817 <u>United States</u> 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. ģ 1 Never Married 2 Married 2 No 1944 1 X Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 1950 Completed 3 XWidowed 4 Divorced Specify: White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <u>Accountant</u> Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည George B. Bisset Lynda Seaman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John C. Bisset/Son 20925 Clarksburg Road, Boyds, Maryland 20841 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, October 18, 4 ☐ Donation 5 ☐ Other (Specify) Rock Creek Cemetery Washington, D.C. 2011 Signature of Funeral Service Ocer Robert A. Pumphrey Funeral Home, Rockville, 300 W. Montgomery Ave., Rockville, Maryland alan now M01530 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ End stage metastatic colon cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Failure to thrive Sequentially list conditions, Directo for an a pormeous real cause. Enter Underlying Examir Hospital or Attending Physician; The law requires that the death certificate be executed 24 hours after death. Cause (Disease or injury that initiated events burial-trar Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? for Month Pregnant at time of death Day Year been signed by the a should be detached t 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 V Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform ec 1 ☐ Yes 2 ☐ No Yes 2 No To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 💢 No Other: ၉ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending work? 2 🗌 No Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c, License number D0057458 October 11, 2011 30. Name and address of person who ophpleted cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State

Registrar

Pinky Singh,

M.D.,

OCT 1 3 2011

#305, Bethesda, Maryland 20814

8218 Wisconsin Avenue,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Physician/ 30 A M CRO Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Randallstown @ Northwest Hospital Seasons Hospice Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye July 10, **Funeral** Age (In vrs. last birthdav) 9. Birthplace (State or Foreign Days 1 □ M 2 🏋 F Maryland **Director** 1915217-07-4850 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 Yes 2X No Catonsville MD <u>Baltimore</u> r must be r ö 10e. Street and Number 10g, Citizen of What Country? Funeral USA 21228 <u>303</u> Maiden Choice Lane #329 "natural", or iten ledical Examiner r 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Yes, Give white 1 ☐ Yes 2 👿 No Specify: 3 X Widowed 4 ☐ Divorced Specify: Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other the any injury or other traumatic event, the I hispiral gift shop cashier Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Sarah Catherine Miller မ John George Jacobs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 14306 Jervis Avenue #106 Ocean City, MD 21842 John Bosley/son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Durial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 🗓 Donation 5 🗆 Other (Specify) in state Ronal d S Signature of Funeral S. 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Director Baltimore, MĎ 21201 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest , or heart failure. List only one cause on each line Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Examiner Sequentially list conditions Examiner Due to (or as a sonesquenes or): cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Cther (specify) in the past 12 months? Day Year Pregnant at time of death Unknown signed by the ar Yes 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate Yes 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Hospital Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c, Injury at work? 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending injury 2 Accident
3 Suicide 1 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \square Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature

Registrar

DHMH 17 Rev 7/2009

State

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

of Vital

Division

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month 1013 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** City, Town, or Location of Death County of Death Randallstown Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 7. Age (In vrs. last birthday 8 Date of Birth Sept. Day Year 1948 1 🔀 M 2 🗆 F Days Min 63 212-50-6331 Director MarvTand Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Reisterstown 1 Yes 2 XNo within 72 hours after death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21136 U.S.A. Caraway Road 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces 2 1 Never Married 2 X Married ☐ Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 7 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Wholesale Florist Sales representative Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Stanley Blank Leda Farnesi permit. Page 1 and 2 should be Department of Health and Mem Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane Blank / Wife Caraway Road, Reisterstown, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place DulaneyValleyMem.Gdns. 10/14/2011 Timonium, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Samue Linguist 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signard by the attandant abusing a control of the control of th Cause (Disease or iinjury burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the for use as IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Dav Pregnant at time of death Unknown signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a Was an prior to completion of cause of death? performed 2 1 No 2 [1 Tes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Hospital 2 **W**No Other: 1 Yes 1 Inpatient 2 1 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural injury 5 Pending ☐ Accident ☐ Suicide Investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check nd address of person who completed cause of death (tem 23a) (Type, Print) Road Randallstown Old Court 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 32573 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) . 2. Date of Death Physician/ Bailey F october Year 12:44PM Medical 2011 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 2409 Arbuton Avenue Baltimore n/a Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🗓 F Days Hours (Month, Day, Year) 10/1/1928 Director 234-42-7824 Virginia 83 Usual Residence of Decedent 28a-f shov 10a. State 10b. County death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits notified MD n/a Baltimore 1 X Yes 2 □ No 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? an "natural", or items 23a o Medical Examiner must be Funeral 2409 Arbuton Avenue USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force þ Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2X No Specify. If Yes, Give Completed 3

Widowed 4 □ Divorced Specify: Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) th and Mental Hygiene. 27 is marked other than traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 8 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Page 1 and 2 should be Ernest Atkins Mary Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health Sheila L. Morris / Daughter 303 Rainwater Way, Suite 304, Glen Burnie, MD 21060 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ot once. 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) Donation 5 Other (Specify) Cedar Hill Cemetery 10/13/2011 Brooklyn Park, MD 21. St nature of Funeral Service License 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Bladder Cancer disease or condition resulting in death) Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami Hospital or Attending Physician; The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): physician a the burial-1 Physician/Medical Division of Vital Records, P.O. Box 68760 the attending phone IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Month Day Year Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 2 No 3 Probably 4 Unknown 1 Yes peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has page 2 certificate 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 No 1 Yes မ this 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 \sum Yes 2 \sum No 5 Pending after death.

Director: Aft
d in by the fur Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29b. Signature and title of certifier NSRy Mane M '0 29d. Date signed (Month, Day, Year) DO057465 10/11/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

N-S. Rajapakse, M.D.

OCT 1 3 2011

31. Date filed (Month, Day, Year)

2835 Smith

1203 By HIMOH MD 21209

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien) for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OCT. 20°11 8:24А м ROBERT L. BREESE Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE'S LANHAM MAGNOLIA CENTER 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) N.C. 1 M 2 □ F Days Hours Months 6/271928 246-30-6977 Director 83 Yrs Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amply injury or other traumatic event, the Medical Examiner must be nortified to once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No MD PRINCE GEORGE'S NEW CARROLLTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7603 RIVERDALE RD #426 20784 UNITED STATES 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Xes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Divorced 4 Divorced Specify: BLACK Completed Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 12th College (1-4 or 5+) HEAVY EQUIPMENT OP. PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ WILLIE BREESE GRACE BREESE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2078 GERALDINE BREESE/WIFE <u>7603 RIVERDALE RD.,</u> #426 NEW CARROLLTON 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) CHESAPEAKE CREM. ! 10/5/2011 BELTSVILLE MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CAPITOL MORTUARY 425 MARYLAND AVE NE WASH 20002 complications that caused the death. Denot enter the mode of dying, such as cardiac or respiratory arrest, nly one cause on each line. 23a. Part 1. Enter the disease Approximate shock, or heart failure. List Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ emen Medical resulting in death) Due to (or as a consequence of): Examiner dio Vasaulan Distas Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and the burial-tran Due to (or as a consequence of): resulting in death) Last led by the attending physician detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? Month Day Yes 2 No g Unknown g Unknown Part II. Other significant conditions contributing to death but not reculting in the underlying cause given in Part I. ate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Yes Yes 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 💢 No ုင 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No. Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14300 GALLANT FOX LANE #222 BOWIE, MD. 20715 RAKESH ARORA 31. Date filed (Months, Day, Year) 🕶 🛶 😼 32. Pogistrar's Signature Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 10 12 Day Mozella Cherry 2011 7:05 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Laurel Regional Hospital Laurel Prince George's Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🔀 F Months Hours Jan 6, 1935 237-62-7810 **Director** 76 Yrs. North Carolina Usual Residence of Decedent 28a-f show 10a. State with the Maryland 10c. City, Town or Location the Medical Examiner must be notified at 10d. Inside City Limits Director MD Prince George's Laurel X Yes 2 No 10e. Street and Number 9 10f. Zip Code 10g, Citizen of What Country? Funeral 23a 9250 Cherry Lane, Unit 3 20708 USA permit. Page 1 and 2 should be filed within 72 hours after death \text{Department of Health and Mental Hygiene.} Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muonee. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black. White, etc. þ 1 X Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 2 🔀 No 1 ☐ Yes 2 No Specify: Specify: Black Completed 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation
. (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Sanitary Aide Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ည Richard Pugh Hester Cherry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hester Cherry (Foster Child) 9250 Cherry Lane, Unit 3, Laurel MD 20708 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ★ Burial 2 Cremation 3 Removal from State wilder s/Cherry Fam. 10/16/2011 4 ☐ Donation 5 ☐ Other (Specify) Aulander, NC 21. Signature of Funeral Service Licens 22. Name and Address of Facility Wilder's Funeral Home 816 Commerce Street, Aulander NC 27805 23a. Part 1. Enter the disease, or condications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) GIST Tumor with Liver Metastasis Medical Due to (or as a consequence of **Examiner** Azotemia, ATN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last CAD S/F CABG, Meningioma Due to (or as a consequence of): Physician/Medical Septicemia, Fungemia Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Pregnant at time of death Year cate has been signed by the a page 2 should be detached to 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 ☐ Yes XX No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed? Yes 2 No after death.

Director: After this certificate 1 Yes 2 🗌 No To the Hospital or Attending Physician: upleted filled in by the funeral director, Be B 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 🛣 No Hospital: Other: ျပ 1X Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending work 2 Accident
3 Suicide 1 Yes 2 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide determined building, etc. (Specify) within 24 hours a

To the Funeral C

completed filled 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Sign ture and title of certifier Sun Sound 00057216 OCT 12, 2011 HY OU AN Name and address of person who completed cause of death (Item 23a) (Type, Print) 3450 Ft. Meade Road, #209, Laurel MD 20724 Michael Baako, M.D.

Registrar

32. Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First Middle Last) 2. Date of Death Physician/ Cunningham Terrance 5:00 AM October 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Seasons Hospice at Northwest <u>Baltimore</u> Baltimore 5. Social Security Number 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 24 Hrs. **Funeral** Days Hours **Director** 213-28-5871 78 1 🔀 M 2 🗆 F 02-19-1933 Maryland Usual Residence of Deceden 28a-f show 10b County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Yes 2 X No Maryland Baltimore Catonsville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 17 Golden Hill Court 21228 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by 1 Never Married 2 Married Yes, Give 1 Yes 2 No Specify: 3 Widowed 4 Divorced Specify: WHITE Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 years Sales Business Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Alfred Morris Cunningham Margaret Taylor Rutley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marsha Cunningham - WIFE 17 Golden Hill Court, Catonsville, MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 🌠 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Metro Crematory INC 10-12-2011 Baltimore, Maryland 22. Name and Address of Facility Cremation Society Of Maryland INC 299 Frederick Road, Baltimore, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ End-Stage COPD disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) executed burial-trai resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE USe 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ detached for in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Pregnant at time of death Day 1 Yes 2 L 9 Unknown g Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed? Yes 2 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Other: 2 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending s after death. 1 Yes 2 No the 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined within 24 hours To the Funeral I Medical 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier

15 Ryapahse M10. 29d. Date signed (Month, Day, Year) 10/12/11 D0057465 completed cause of death (Item 23a) (Type, Print) N. S. Rajapakse, M.D. Baltimore MD 21209 S Zaz 2835 Smith 31. Date filed (Month, Day, Year, 32. Registrar's Signatur State

Registrar

3 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 201 35p 8: 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 1809 Vine Street Baltimore 7. Age (In yrs. last birthday) If Under 1 **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days 1 🗆 M 2 👿 F Months (Month, Day, Year) Hours Country **Director** 216-42-4227 66 3Ö Usual Residence of Decedent 28a-f shov 10a. State with the Maryland 10b. County 10c. City, Town or Location be notified at 10d. Inside City Limits Director 1 Yes 2 ☐ No MD NA Baltimore ò 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 1809 Vine Street 21223 U.S.A. death \ 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ō þ 1 Never Married 2 Married 1 Yes 2 **N** Baltimore, Maryland 21215-0036 filed within 72 hours after 1 Yes 2 No Specify: "natural" Completed 3 X Widowed 4 Divorced Specify: Black Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me any injury or other traumatic event, the Me once. Elementary/Seconday (0-12) College (1-4 or 5+) 12th grade na Packer Factory I. Sekine Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Elzie Foreman <u>|Annie Mae Oneal</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wayne Pinkney-Son 1809 Vine Street, Baltimore, Md 21223 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State cemetery, crematory or other place. 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest 10/21/2011 Owings Mills, Md 21 at re of Funeral Service Licenses 22. Name and Address of Facility March F/H West Baltimore, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Dav the a 1 ☐ Yes 2 ☐ Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s this certificate has autopsy perform Yes Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 Tes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Funeral Director; After Hospital or Attending 1 Natural 2 Accident 5 Pending the Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, after determined City or Town, State) Medical 29a. Certifier 1 Gertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 40064767 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierie 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** rawford October 4, 2011 12:40 AMM leno /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Future Care Canton If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country)
 unk 8. Date of Birth (Month, Day, Year) Dec 3, 1944 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☑ M 2 ☐ F Director 242-68-8560 66 Usual Residence of Decedent death with the Maryland 7 is marked other then "naturel", or leams 23a or 28a-f show treumatic event, the Medical Eventrer must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1√2 Yes 2 No MD Baltimore Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 600 N. Ellwood Avenue 212205 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If them 27 is marked other then "naturet", or Item eny injury or other treumatic event, tre Medical Exemina Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: black 1 ☐ Yes 2 X No Specify: þ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) unk unk 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) unk unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Future Care Canton 1300 S. Ellwood Avenue Baltimore, MD 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State '4 □Donation 5 ☒Other (Specify) in state 21. Sign tune of Funeral S. ²² State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Final disease or condition resulting in death) a Metastatie tonque conciroma. **Physician** ew north /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Ellar Urbarying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. attending physician Physician/Medicai esn IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mon Day 4 Pregnant at time of death 5 Other (specify) P.0. the 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown s been signed by the should be detach. Part I. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ erestou Meda Accident 1 Yes 2 No 3 Probably 4 Honknown ted Complet sax tes 24b. Were autopsy findings available prior to completion of cause of death? has page 2 autopsy performed certificate Nupertipits 2 No Division of Vital 2 1 Yes 1 Yes To the Hospitel or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ No Other: 4 Desire the Series of Other (Specify) 10 After the 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of Certification; 28c. Injury at Work? 28d. Describe how injury occurred 1 Anatural 5 Pending hours after death. investigation M 1 ☐ Yes 2 ☐ No 2 Accident Director 6 Could not be determined 3 T Suicide in by t Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a filled 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D1966 10-06.2011 teeooup

Registrar DHMH 17 Rev 1/2001

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Timoul 31. Date filed (ACC) completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2011 P^{M} Medical Jane Nicoll Chambers October 0 6:04 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Gilchrist Hospice of Howard County Columbia Howard If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 XF Months Hours Min. (Month, Day,) 5/30/2 Director Maryland 212-20-6949 Usual Residence of Decedent show 10a. State notified at 10c. City. Town or Location 10d. Inside City Limits Director 28a-f s 1 Yes 2 No MD Baltimore Catonsville 10e. Street and Number ö 10f. Zin Code 10g. Citizen of What Country? must be Funeral 23a 709 Maiden Choice Lane Apt. S115 21228 items 2 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, traumatic event, the Medical Examiner Black, White, etc. ō þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", 3 Widowed 4 Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) id Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file h and Mental F 7 is marked o ည William Nicoll Augusta Bond 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s if Health item 27 David Harry Chambers Jr. / Son 218 Edridge Wav Catonsville, Maryland 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Crematory 10/13/11 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Maryland 21229 23a. Part 1. Errer the disease, or shock, or heart failure. List of omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death filv one cause on each line Immediate Cause (Final Physician Gangrene disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial-Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death signed by the a d be detached f g Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Nonknown 24b. Were autopsy findings available 24a. Was an has prior to completion of cause of death? autopsy performed page certificate Colon Cancer 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospital: 2 No ပ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After (Month, Day, Year) Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after death To the Funeral Directors, completed filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DO060634 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6336 EDARLANE BINDU. JOSEPH

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month EVERTA J. CROWNER 2011 10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death BALTIMORE SINAL HOSPITAL OF BALTIMORE N/A J.CROWNER 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours Min (Month, Day, Year) Director 218-36-6565 73 1 - M 2 X F 8-31-1938 MARYLAND Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location must be notified at Director MD. N/A BALTIMORE 10e. Street and Number ō 10f. Zin Code 10g. Citizen of What Country? Funeral items 23a 901 CHERRY HILL RD. APT 270 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? 1 Yes 2 XNo Black, White, etc. by "natural", or 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Completed 3 X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) nd Mental Hygiene.
s marked other than "ı
ımatic event, the Mec Elementary/Secondary (0-12) College (1-4 or 5+) -12--0-MACHINE OPERATOR FACTORY Be KNOWN 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Surname) and Mental F ည SAMUEL McLOWRIN RACHELL SMALL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trat once. GARY CROWNER (SON) 5311 HAZELWOOD AVE. BALTIMORE, MARYLAND 21206 TIENT 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Crema tion 3 Removal from State ARBUTUS MEMORIAL PARK 10-12-2011 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MARYLAND 21. Signature Funera Se & Lice see HIBNER Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Immediate dause (Final SHOCK Ph sician/ CARDIOGENIC disease or condition resulting in death) Medical Examiner MYOCARDIAL INFARCTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last attending physician and I for use as the burial-tran Due to (or as a consequence of): Physician/Medical that the death certificate be P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Consent at time of death 5 Other (specify) 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? Month 1 Yes 2 No detached the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires 24 hours after death.

Funeral Director, After this certificate has been sign Division of Vital Records, 2 Diabetes Mullitus, End Stage renal disease 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Vascular di seers Yes 2 No 1 Yes 25. Was case referred to medical examiner?

1 Yes 2 No filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospi within 24 hou To the Funer completely fil Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) V. Pramanik 201 RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OF SINA HOSPITAL VEDATRAYETE YRAMANIK MBBS OCT 13 2011 32. Registrar's Signature

3. Time of Death

10d. Inside City Limits 1 x Yes 2 No

Approximate Interval Between

Onset and Death

5 DAYS

5 DAYC

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ORIGINAL

Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 32581 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Carole Α. Coscia 0ctober 2011 5:22 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Towson 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) Hours 215-58-4676 Director 1 🗆 M 2 🗶 F 57 Yrs Sept 6, 1954 Maryland Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director MD. Baltimore Perry Hall 1 Yes 2 X No 10e. Street and Number 23a or 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21128 4312 Silver Spring Road USA "natural", or items Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White 3 - Widowed 4 - Divorced 27 is marked other than "natur traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Registered Nurse Nursing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Mesmeringer **Brooks** Nicie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trau once. Samuel G. Coscia, Jr./ Husband 4312 Silver Spring Rd. Perry Hall, MD. 21128 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗶 Burial 2 🗆 Cremation 3 🗆 Removal from State St. Joseph Church 10-15-11 Fullerton, MD. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Line see 22. Name and Rides of Towson Funeral Home, 1050 York Rd. Towson, MD. 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the bunal-trar that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ signed by the atter in the past 12 months? Month Dav Year Pregnant at time of death 1 | Yes 2 | 9 | Unknow Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform Yes 2 No 2 🗌 No 1 🗌 Yes Be 25. Was case referred to medical the funeral director 26. Place of Death (Check only one) examiner? Hospital Other: ဂ္ 1 🗌 Yes 2**X** No 1 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpa 4 ☐ Nursing Home 5 ☐ Residence 6 Nother (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 3 Suicide 4 Homicide 6 Could not be completely filled in by Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature an 29d. Date signed (Month, Day, Year) \mathcal{M} . \mathcal{D} . D0071187 10-11-11 Name and address of person who completed cause of death (Item 23a) (Type, Print) 4105, Baltimere, MO 21204 Wilip Shaheen, 6701 State

Registrar

DHMH 17 Rev 7/2009

State Registrar

29b. Signature and ti

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ss of person who completed cause of death (Item 23a) (Type, Print). Charles St. Swite 4105, Baltinere, MD 21204

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Marylan		artment of He rtificate of De			201	1	32583
	Physicia	.m/	Decedent's Name (First, Middle, Last)		-	0110010 0	-	2. Date of Deat			3. Time of Death
	Medic	cal	Betty R. 4a. Facility Name (if not institution, give s	Darnell		T		October	8, 201		11:32 A™
mount	Examin	ier	4a. Facility Name (if not institution, give s Gilchrist Center	reet and number;		4b. City, Town, or L Towson			4c. County o	of Death L timo 1	ro
	Funeral	1	5. Social Security Number 6. Sex	J	ast birthday)		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,			lace (State or Foreign
	Director		236-12-1887 1 Dusual Residence of Decedent	^{3 M 2 X F} 94	Yrs.		, , , , , , , , , , , , , , , , , , , ,	Sept 26			 Virginia
	yland -f shov ed at	cto	10a. State 10b. County	10c. Cit	y, Town or Loc	cation				10	Od. Inside City Limits
	ie Mary ir 28a- notifie	Director	Maryland Baltimo	re	То	WSON			71		1 ☐ Yes 2 🛣 No
	with th	eral	400 Georgia Court			10f. Zip Code 2120	14		10g. Citizen of W USA	hat Counti	ry?
	death	Funeral	11, Marital Status	12. Was Decedent Ever in U.S Armed Forces?		Was Decedent of Hisp f Yes, specify Cuban,	panic Origin? (Spe		14. Race	- America	
36	after al", or xamii	d by	1 Never Married 2 Married 3 🕱 Widowed 4 Divorced	1 ☐ Yes 2 🔀 No If Yes, Give		Fres, specify Cubari,		nican, etc.,	Specific	K, White, et	
5-00	hours natura dical E	olete	15. Decedent's Edu			lent's Usual Occupat			16b. Kind of Bus	wnit	
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d 2	Hygie Other ent, th	Bec	12 17. Father's Name (First, Middle, Last)	n/a	Hom	emaker_	18. Mother's Name	Firet Middle A	Own H		
/lan	d be fill Jental arked atic ev	၉	Thomas B.	Dye	<u>.</u>		Bessie		raiden surname) Gay		lins
Baltimore, Maryland 21215-0036	should and h		19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailin	ng Address (Street an			-		ode)
e,	and 2 Health tem 27		Joan K. Newlin/Dau 20a. Method of Disposition			Springsid sition (Name of					Ot-t-
mor	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 X Burial 2 ☐ Cremation 3 ☐ F	Removal from State	emetery, crem	natory or other place) alley Memo	1 20/ 1	3/11	20c. Location - (-	
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	B B Z ⊆ B B	Ш	Bryan W. Clary	- Con-		emmon Fun 0 W. Pado	nia Road	. Timoni	Lum. MD	2109	3 Inc.
			23a. Part 1. Enter the disease, or compli- shock, or hear failure. List only one Immediate Cause Final	cause on each line.				r respiratory arre	st,		Approximate Interval Between Onset and Death
	Physician/ Medical		disease or contion resulting in death)	Due to (or as a consequ	IUS W	lar ohis	1051				veurs
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	sit sit	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as a co <i>n</i> sequ	ience of):						
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09	cate be executed physician and s the burial-transit	edical									
6876	iaw requires that the death certificate be executed ras been signed by the attending physician and a 2 should be detached for use as the burial-transi		IF FEMALE:								
Box	ath ce attend I for us	Physician/M	in the past 12 months?	Bc. If yes, outcome of pregnar 1 Live Birth 2 Fetal 4 Pregnant at time of de	ıl death 3 🗌	Ectopic pregnancy Other (specify)			23d. Date Mon	e of deliver	ry Day Y ear
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, P.O	requires that the death certific been signed by the attending p should be detached for use as	þ	Part II. Other significant conditions conf	ributing to death but not resu	ulting in the ur	nderlying cause giver	n in Part I.				e cause of death?
rds	require Deen si Should	Completed	Dementic					1 □ Y€			ably 4 Unknown
Division of Vital Records,	e law r e has b age 2 s	dmc						24a. Was ar autops perforn	y pr		sy findings available apletion of cause of
E E	an: Th rtificatr ctor, pe	Q	25. Was case referred to medical			26. Plac	e of Death (Check	1 Yes 2		☐ Yes 2	! □ No
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0	ding P h. After t funer	:ate:	27. Manner of Death 1 Natural 5 Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury a work?	at 2	28d. Describe ho			
<u>S</u>	Attendary deat ector; by the	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor			es 2 🗆 No	28f. Location (Str	reet and Number	or Rural R	Route Number,
2	ital or irs afte ral Dira led in			building, etc. (Specify)				City or Town,	, State)		
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director After this certificate has completely filled in by the funeral director, page 2:	Medical	(Check 2 \(\subseteq \text{ Medical Examine} \)	ian: To the best of my knowle r: On the basis of examination	ı and/or investi	gation, in my opinion,	, death occurred at	the time, date and	d place, and due t	to the caus	se(s) and manner stated.
	Vithin To the comple		only one) 3 L Certifying Nurse 29b. Signature and title of certifier	Practitioner: To the best of m	ny knowledge, o	death occurred at the	time, date and plac	ce, and due to the	cause(s) and ma	Month Da	ated.
			wh r.	leh		0007	72635		101814		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
			30. Name and address of person who con	npleted cause of death (Item :	23a) (Type, Pr	int)	- 1.	7	1 11		2120
Ì	State	2	31. Date filed (Month. Day, Year)	32. Registrar's Signati	Chan	105 5	MHE	4105	Buch	um	MO
	Registra	~	OCT 1 3 2011	Jengue B.	Mark						

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Maxine L. Douglass Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death County of Death Allegany Western MD Regional Med Center Cumber land 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, June 10 **Funeral** 9. Birthplace (State or Foreign Days Hours Min Months Director 213-24-7147 Mary Land June 1929 Usual Residence of Decedent shov 10a. State 10b. County at 10c. City, Town or Location 10d. Inside City Limits Director rms 23a or 28a-f sh rmust be notified a MD 1 Yes 2 X No **Allegany** Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 704 Hilltop Drive 21502 USA 27 is marked other than "natural", or items traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 and 2 should be filed within 72 hours after c if Health and Mental Hygiene. Item 27 is marked other the... Black, White, etc þ 1 Never Married 2 Married ☐ Yes 2 🗓 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🕅 No Specify. white 3 X Widowed 4 Divorced Specify Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Sarah Gladys Shipley James Carl Stouffer 19a. Informant's Name/Relationship (Type, Print) 3b. Mailing Address (Street and Number or Rural Route Number, City of Town, State Zio Code) 704 Hilltop Drive Cumberland, MD 21502 William C. Keating/son other 1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H
Important: If ite
any injury or ot Date 20c. Location - City or Town, State 1 🗆 Burial 2 🗀 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 🛛 Other (Specify) in state Signat Funeral Service icensee State Affatomy Baord 655 W. Baltimore Street MDtimore, Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Card disease or condition Medical resulting in death) Due to (or as a consequence **Examiner** Sequentially list conditions, Examine ir any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed tran resulting in death) Last Due to (or as a consequence of): physician Medical Division of Vital Records, P.O. Box 68760 attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death Day Year 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performed? Yes 2 No certificate 2 No Be 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Hospital: Other: 2 100 1 🗌 Yes ျ 1 Inpatient 2 ER/Outpatient 3 IDOA After this 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred s after dea... ral Director: After 1-Natural 5 Pending work? 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined building, etc. (Specify) Medical Lacertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying worse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 10033280 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

Sunil Kumar Gupta

OCT 1 3 2011

31. Date filed (Month, Day, Year)

Cumberland, Maryland

625 Kent Ave #101

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) October 7, 2011 **Physician** 1:40 Bryan W. Dillon /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Havre de Grace Harford Memorial Hospital 8. Date of Birth (Month, Day, Ye 9/3/1926 9. Birthplace (State or Foreign Country) West Virginia If Under 1 Year | If Under 24 Hrs. 5. Social Security Numberunk 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1**⊠** M 2□ F 85 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic event, ir a "Medical Examiner must be rediffed at once. 1√Yes 2□No Director MD n/a Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2512 **USA** 21230 Marbourne Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X es 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married White 1 □ Yes 2 XNo Specify. 9 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 10 0 Warehouseman Warehouse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Harriet Miller James Paul Dillon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2512 Marbourne Avenue, Baltimore, Maryland 21230 Keith B. Dillon / Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 10/11/2011 Elkridge, Maryland Meadowridge Mem. Pk □ Qonation 5 ☐ Other (Specify) 22. Name and Address of Facility Hubbard Funeral Home, Inc. Signature of Funeral Service at Insee 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician pulmonary disease or condition resulting in death) /Medical Due to as a consequence of): Examiner 5e 1515 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a con equence of) tract urinary burial-tran resulting in death) Last Due to (or as a convequence of): physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 5 ☐ Other (specify) 1 □Yes 2 □No Ö the detached 9 Unknown 9 Unknown þ s been signed b should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autopsy performed? The 1 ☐ Yes 2 🗷 No certificate 1 TYes Vital To the Hospital or Attending Physician: 26. Place of Death (Check only one) Be 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To of After thi funeral 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death Division 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. neral Director: A 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide hours after within 24 hours a

To the Funeral C

completely filled 😾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAMPSON 32. Registrar's (Month, Day, Year) State 3 2011 Registrar

M DHMH 17 Rev 1/2001

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State of Maryland / Dep Registrar Ce	partment of Health and Nertificate of Death		2011 32587					
	Physicia		Decedent's Name (First, Middle, Last) George O. Ecker		2. Date of Death	3. Time of Death 12:26 AM M					
, , and a sing	Medi Examir		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	OCCODEL	4c. County of Death					
"Annaged"	Funeral	P	Gilchrist Hospice 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Columbia If Under 1 Year If Under 24 Hrs.	O Data of Birth	Howard					
	Director		218-34-0514	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Nov 19,	9. Birthplace (State or Foreign Country) Maryland					
	and show lat	5	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits					
	Maryli 28a-f otifiec	Director	MD Carroll Westm	inster		1 ☐ Yes 2 💢 No					
	ith the 23a or st be n		10e. Street and Number 517 Mark Drive	10f. Zip Code 21157	10g	. Citizen of What Country? USA					
	leath w	Funeral		Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian,					
36	after o	b	1 Never Married 2 Married 1 V Yes 2 No	If Yes, specify Guban, Mexican, Puerto 1 ☐ Yes 2 ▼ No Specify:	Rican, etc.)	Black, White, etc. Specify: white					
2-0	hours "natur dical E	olete	15. Decedent's Education 16a. Dece	edent's Usual Occupation	. 16	b. Kind of Business Industry unk					
121	ithin 72 ene. • than '	Completed		kind of work done during most of work DO NOT use retired)	ing						
pd 2	filed w al Hygi i other vent, t	Be	17. Father's Name (First, Middle, Last)	salesperson 18. Mother's Nam	e (First, Middle, Maid	den Surname)					
Ŋa	uld be d Menta marked natic e	မ	William Donald Ecker		e Elizabet						
Ma	d 2 sho alth and 27 is r	ij	19a. Informant's Name/Relationship (Type, Print) 19b. Mail Denise Altland/stepdaughter 969	ing Address (Street and Number or Rura Pinch Valley Road	al Route Number, Cit l Westmins	y or Town, State, Zip Code) ster, MD 21158					
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. In marked other than "natural", or items 23a or 28a-f show any figury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	osition (Name of matory or other place)	Date 20	c. Location - City or Town, State					
Balt	permit. Departi Import any inji			fate and Address of Facility and altimore, MD 2120		altimore Street					
)	h sician/ Medical Examiner	ər	23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause final disease or condition resulting in death) a	ter the mode of dying, such as cardiac o	or respiratory arrest,	Approximate Interval Between Onset and Death MONTHS					
09	certificate be executed nding physician and use as the burial-transit	dical Examiner	If any, leading to immediate cause. Enter Underlying Gause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):								
XO E	dearn ne atte ed for	Physician/Me	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 12 case 12 case 12 case 12 case 13 case 14 case 15 cas	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year					
О.	gnec gnec	اج	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		co use contribute to the cause of death?					
ords	been s	leted	Chronic Obstructive PulmonAR	y DISCASE		2 No 3 Probably 4 Winknown					
Records,	cate has	Completed			24a. Was an autopsy performed						
VITAL	s certifi	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: I Inpetient 2 FB/Outpetie	26. Place of Death (Check		1-05					
on or		27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury (Month, Day, Year) 28c. Injury at work? 1									
DIVISION	rrs after de ral Directo	al Certii	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)					
the Hoen	thin 24 hot the Funer mpleted fil	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or investonly one) 3 Certifying Nurse Practioner: To the best of my knowledge,	tigation, in my opinion, death occurred at death occurred at the time, date and place	the time, date and pl e, and due to the cau	ace, and due to the cause(s) and manner stated. se(s) and manner as stated.					
٩	. ≥ . 5		29b. Signature and title of certifier A. J. J. D. A. C. D. D.	29c. License number RN47326		Date signed (Month, Day, Year)					
		-	30. Name and address of person who completed gause of death (Item 23a) (Type, I	RO47324 36 Cedas LANE	100	TOURNES, JOIL					
	State				Columb	21A Mi) 21044					
	Registra	7	OCT 13 2011 Serva B. Ja	Med							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien () For State Registrar Certificate of Death Reg. No. 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Day 2011 SEPT. **Physician** 7:25 PM M 18, FORD MARVIN /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 5300 Newton Street #310 Bladensburg If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1□ M 2□ F Months NC 03-24-1927 277-32-0199 84 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County a Hygiene. Jother than "natural", or itema 23a or seevent, the Medical Examiner must be notified at Yes 2 □ No Directo Bladensburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5300 Newton Street, #310 20770 US 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 20 No If Yes, Give 14. Race - American Indian Black, White, etc. 2 should be filed within 72 hours after () and Mental Hygiene. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes XXNo Specify Specify: þ Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4th DC Public Schools Cook 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Williams . Peges 1 and 2 should by timent of Health and Menta tent: If Item 27 is marked jury or other traumatic so Maude Ford John. ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3410 55th Avenue #402, Hyattsville, Md Deidre Ramos (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3 □ Removal from State permit. Pege Department important: If any Injury or once. Lincoln Cont Bladensburg 09-26- h 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert G. Mason Funeral Home 1661 Good Hope Rd, SE, Wash. DC 20020 Approximate Interval Between Onset and Death 23a. Part 1. Entire the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Gastric Cancer **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Ener Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-transit Due to (or as a consequence of) physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of deliven 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably XX Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 X No After this certification Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 52 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 1 X Natural 5 Pending 1 Tes 2 No death. investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, within 24 hours after death To the Funeral Director: , completely filled in by the f To the Hospital

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MD 09-20-2011 D63748 belune Koualchou

State Registrar 30. Name and address person who completed cause of death (Item 23a) (Type, Print) 4041 Powder Mill Rd. Calverton, Maryland 20705

31. Date filed (Month Day, Year OCT 13

22. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Feather Betty Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner 39 Brent wood If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace Social Security Number 6. Sex **Funeral** Days Hours Min. $0ct. \stackrel{(Month, Day, Year)}{11}, 1940$ Washington DC 1 🗆 M 2 💢 F Months 71 Director 578-54-9998 Usual Residence of Decedent 28a-f show 10d, Inside City Limits 10a. State 10b. County 10c. City, Town or Location items 23a or 28a-f sho ler must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Brentwood Maryland Prince George's 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20722 3416 39th United States Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S 11. Marital Status the Medical Examiner ō ģ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2√√ No Specify: White "natural", Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Office Worker Accounts Payable of Health and Mental Hygi item 27 is marked other other traumatic event, i Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Maragret Unknown Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or other trau 3416 39th Avenue, Brentwood, Maryland 20722 Robert Feather / Husband 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other place, ☐ Burial 2 XCremation 3 ☐ Removal from State Metro Crematory Inc. 10/13/2011 | Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Cremation Society of Maryland 21. Signature of Funeral Service Licensee Alvson K 299 Frederick Rd., Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final plications Physician/ Con disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) burial-transit and Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 month Day 5 Other (specify) Pregnant at time of death signed by the a d be detached f 1 ☐ Yes 2 년 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 🗌 No 3 Probably 4 Unknown page 2 should been s 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 has Director: After this certificate or Attending Physician: completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Medical Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1-Natural 5 Pending work? 2 No Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined after To the Hospital within 24 hours Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my coursed at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month (O Year JOhn A. Foehrkolb Sr. 1159 PM 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FRANKLIN Square Rosedale Hospital Baltimore 6. Sex If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan7,1920 **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 217-16-6610 1 XM 2 🗆 F Days Hours Min. Director 91 MD Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Essex 1 ☐ Yes 2 🙀 No 10e. Street and Number ō 10f. Zip Code er than "natural", or items 23a or the Medical Examiner must be 10g. Citizen of What Country? Funeral 2907 Breezy Point Court 21221 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐xNo Specify. White Completed 3 XWidowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Eastern Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene, is marked other tha Steel Worker 8th Stainless Steel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Andrew Foehrkolb Dora Addicks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t: If item 27 is or other tra Joan Buchanan /daughter 346 LeeAnne Road Baltimroe MD 21221 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State f Department o Important: If any injury or once, 1 X Burjal 2 Cremation 3 Removal from State Oak Lawn Cemetery 10/14/11 Fo Baltimore MD 4 Donation 5 Other (Specify) atu Funeral Jewice Lich see 22. Name and Address of Facility 300 MAce Ave. Balto. MD Connelly Funeral Home of Essex 21221 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Acate Lower GI hemorrhag 10 min Medical Examiner Probable MesenTeric Ischemia 1-2 hours Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine attending physician and or use as the burial-transit that initiated events resulting in death) Last de th certificate be execu Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 1 ☐ Yes ∠ ☐ 9 ☐ Unknown be detached the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy performed? certificate Notice treatment of the funeral Director. After this certific:

To the Funeral Director. After this certific: or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work?
1 Yes 2 No ☐ Accident ☐ Suicide Investigation M 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10-12-2011 RESOOOO 30. Name and address of person who completed eause of death (Item 23a) (Type, Print) FRANKLIN SQUARE DR Balto 9000 md 21237 DR David D 31. Date filed (Month De

Registrar DHMH 17 Rev 7/2009

State

13

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death Day Physician/ Month Charles Towner French, Jr October 39 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. Months | Davs | Hours | Min. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year October 7, 1 1 ₹ M 2 □ F New York (2) **Director** 216-50-7238 1946 Usual Residence of Decedent 28a-f shor 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland **Funeral Director** must be notified 1 Yes 2 X No Maryland Montgomery Germantown 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 14 Sunnyview Court 20876 United States "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 X Yes 2 No
If Yes, Give Black White etc. <u>S</u> 1 Never Married 2 X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify FRENCH Specify: White Completed 3 Divorced 4 Divorced Year or Dates. Vietnam the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Editor Financial Newsletter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charles Towner French Helen Rose Kussin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Sally S. French/Wife 14 Sunnyview Court, Germantown, Maryland 20876 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of I Important; If ite any injury or ot once, montgomery

Montgomery October 14, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2011 Bethesda, Maryland Crematorium. Inc. Robert A. Pumphrey Funeral Home, Rockville, Inc. 300 W. Montgomery Ave., Rockville, Maryland 20850 21. Signatule of Funeral Service Licensee Houan 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Enysician/ cardionalmonar arrest disease or condition resulting in death) Medical **Examiner** hemoly tic anemia Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Examine Due to (or as a opnsequence of): Cause (Disease or linjury and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physiciar Physician/Medical law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the l IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ō Month Year Day Pregnant at time of death :he Unknown · by 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy l or Attending Physician; The I after death. perform this certificate Yes 2 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 🔀 No Other: ဂ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Director: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 000 67512 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Center Drive, Rockville, MD Bangalore, 9901 Madical 31. Date filed (Mo nth, Day, Year 32. Registrar's Signature State 1 3 2011 Registrar

ORIGINAL

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Deepdent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month GEORGE GARRETT 9:05 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GEORGIA AVENUE SILVER SPRING MONTGOMERY 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)
Yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** 9. Birthplace (State or Foreign Sex 1 M 2 □ F 206-20-6335 Country) Director Usual Residence of Decedent show 10a. State 10b. County the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f MONTGOMERY VER PRING 1 Yes 2 No 10e. Street and Number ŏ 10f. Zip Code 10g, Citizen of What Country? Funeral 23a (TEORGIA 20906 USA items 2 within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ò δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: BLACK "natural", Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important if item 27 is marked other than any injury or other trainmatic. Elementary/Seconday (0-12) College (1-4 or 5+) PRIVATE UPERVISOR Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ COLON HUNTER FENRIETTA 19a. Informant's Name/Relationship (Type, Print) CHYRAN GARRETT-DONALDSON DAUCHTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2600 NAYAJO PATH, AMBLER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 10-15-11 FERNWOOD, PA ERNWOOD CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 814 UPSHUR ST NW SERVICE WASHINGTON DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Rostate disease or condition resulting in death) cance UR3 Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) transit-Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): burial-1 attending physician Physician/Medical Box 68760 the t ast IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 2 should be detached 1 ☐ Yes ∠ ☐ 9 ☐ Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy pade death? performe Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 No Other: ျ To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this or 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending work 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. RO64229

Registrar

State

sington MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For Amen dItem 25 State of Maryland / Department of Health and Mental Hygiene State Per me, g921, 11/01/2011 dhb Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Year **Physician** Vera iveer 01:47 AM 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** if Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 😿 F 218-14-6419 Yrs. 87 Director Jan. 9,1924 Pennsylvania Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantation 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Tyes 21 No Baltimore Dundalk 10e. Street and Numbe 10f. Zip-Code 10g. Citizen of What Country? Funeral 103 Center Place Apt. 110 21222 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes ②☐ No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: à 3 Widowed 4 □ Divorced Specify: Year or Dates: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) 11 Years Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nicholas Golia ည Maria Venuto 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen Green (Daughter) 3537 Dunhaven Road Dundalk, Maryland 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cem. 10/12/2011 Baltimore, Maryland 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signature of Funeral Service Licenses 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Applications of the disease of complications and caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Applications of the disease of the death of the Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Intrucerebral Hemornas Chour /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any leading to himociate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or se a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transif and CERTIFICATION resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Day Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed; 2 X No 2 🗌 No certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 X Yes 2€No Hospital: 1 Inpatient 2 - ER/Outpatient 3 - DOA Other: $_{4} \square$ Nursing Home မ 5 Residence 6 Other (Specify) this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation After 1 Natural Injury death. 2 Accident 1 Yes 2 No by the 1 Director: 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide after filled in t 24 hours 29a. Certifier (check only 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of contille 29c. License number 29d. Date signed (Month, Day, Year) Kesident RFS-00 October 8,2011 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mawniqua TiWilliams 4940 Eastern Avenue, Baltimore, MD, 21224 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State back Registrar

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of I	Marylan		artment of I		and Me	, ,	001	1 32594	
			Registrar 1. Decedent's Name (First, Middle)	e, Last)		Cer	uncate or t	Jeaur	2	. Date of Dear	th	3. Time of Death	
	Physicia Medi		Alice Gadol							Month October	Day 11, 20	Year	Л
	Examin		4a. Facility Name (if not institution)		4b. City, Town, o	r Location o			4c. County o		
-			Gilchrist Hos 5. Social Security Number					umbia	VIII market			oward	
	Funeral Director		579–18–4601	6. Sex 7. /	Age (In yrs. I 91	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	. Date of Birth (Month, Day,	Year)	Birthplace (State or Foreign Country)	n
	wo		Usual Residence of Decedent							Oct. 8,	1920 11	Pennsylvania	
	ryland -f sho	ctor	10a. State 10b. County		10c. Cit	y, Town or Loc						10d. Inside City Limits	
	ne Ma or 28a notif	Director	MD Howa 10e. Street and Number	ard		C	olumbia T10f. Zip Code					1 Yes 2	lo
	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Funeral	9444 Ridgevie	w Drive				046			10g. Citizen of Wh In ite	d States	
	death items ier mi	F	11. Marital Status	12. Was Deceden		S. 13. V	Vas Decedent of H	ispanic Orig	in? (Specify	Yes or No-		- American Indian,	
36	after or I", or kamin	l by	1 ☐ Never Married 2 ☐ Mar 3 🔀 Widowed 4 ☐ Divorced	1 1 103 2	No		Yes, specify Cuba		Puerto Ric	an, etc.)	Black, Specify:	, White, etc.	
21215-0036	atura cal E	Completed		Year or Dates			ent's Usual Occup					White	_
215	in 72 l e. nan "r	J mg		est grade completed) College (1-4 o	r 5+)	(Give k	ind of work done of NOT use retired)	during most	of working		16b. Kind of Bus	iness industry	
21	ed within Hygiene. other tha	Be Co		4		Ho	memaker				Own	Home	
Maryland	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	To B	17. Father's Name (First, Middle, I Willmer Curt	,							Maiden Surname)		
ary	nd Me nd Me mark		19a. Informant's Name/Relationsl			10b Mailin	g Address (Street a			a May		oto Zio Ocelol	
	and 2 should be file Health and Mental em 27 is marked of ther traumatic eve		Dorothy Burke				4 Ridgev						
Baltimore,	a. U 4- L		20a. Method of Disposition	2 Demousi from Ste		lace of Dispos	sition (Name of latory or other place		Date	е		City or Town, State	
ţ	permit. Page Department o Important: If any injury or once.		1 Burial 2 Cremation 4 Donation 5 Other (S			tro Cre	ematory		0/12/			ce, Maryland	
Ba	permit. Page Department Important: I any injury o		21. Si ure of Fune Service L	icensee	Do		Name and Addres						
			23a. Part 1. Enter the disease, or shock, or heart failure. List of	complications that caus	ed the death							Approximate Interval Between	
	Physician/		Immediate Cause (Final disease or condition	Com	olic	ation	ns c	of '	Der	nen	tia	Onset and Death	
	Medical Examiner		resulting in death)	Due to (or a	s a consequ	ience of):						(
١.		ner	Sequentially list conditions, if anleadin_ to immediate	b. Due to for a	e a nonsacu	ence off							\dashv
	uted id ansit	Examine	cause. Enter Underlying Cause (Disease or iinjury that initiated events			,							
	ate be executed physician and the burial-transit	EX	resulting in death) Last	Due to (or as	s a consequ	ence of):							=
09	ate be ohysic the bu	dical		d									_
687	ertific ding p	/We	IF FEMALE:	23c. If yes, outcom	e of pregnar	ncv							\exists
Box 687	r requires that the death certifics been signed by the attending p should be detached for use as t	Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live Birth 4 ☐ Pregnant	2 Feta	death 3	Ectopic pregnanc Other (specify)	у			23d. Date Monti	· ·	Ì
П	the d by the tached	hys	9 Unknown	9 🗌 Unknowr	1								
. P.O.	ss that igned be de	by	Part II. Other significant condition	ns contributing to death	but not resu	ulting in the un	derlying cause giv	en in Part I.				oute to the cause of death?	
rds	equire	eted	Atrial +	BYILLAL	100				_	1 🗌 Ye	es 2 🗆 No 3	Probably 4 Nnknow	'n
၀၁ .	has b	dm								24a. Was ar autops perforn	y pri	ere autopsy findings available for to completion of cause of eath?	;
Ř i	rsician: The law s certificate has be lirector, page 2 s	ပ္ပို	25. Was case referred to medical	-			00.5		101	1 Yes 2		Yes 2 No	_
Z Its	ysicia is cert direct	To Be	examiner? 1 Yes 2 No	Hospital:	tient 2 🗆 I	ER/Outpatient	Othe	er:			nce 6 Other	(Specify) Hospice	0
ō i	ng Ph fter th meral		27. Manner of Death 1 Natural 5 □ Pendin	28a. Date of inj	jury	28b. Time of injury	28c. Injury work	at			w injury occurred		_
loi.	ttendi death. tor: A the fu	Certificate:	2 Accident Investig	ation			M 1 🗆	Yes 2 N	No				
Division of Vital Records,	Ial or Attending Physician: The Is rs after death. al Director. After this certificate had in by the funeral director, page		4 Homicide determi	28e. Place of In	iju r y - At hor tc. <i>(Sp</i> ec <i>ify)</i>	ne, farm, stree	et, factory, office		28f.	Location (Str City or Town		or Rural Route Number,	
	To the hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Bractor after this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	ledical	(Check 2 \(\sum \) Medical E:	Physician: To the best of caminer: On the basis of	examination	and/or investig	gation, in my opinio	n, death occ	urred at the	time, date and	d place, and due to	o the cause(s) and manner state	ted.
ŀ	vithir To the	Σ	29b. Signature and title of certifier	Nurse Practioner: To the	C Deat Of His	mowieuge, de	29c. License		nu piace, a			Month, Day, Year)	
			Banv				Doc	060	634		10/11/	//	
(0			30. Name and address of person v	tho completed cause of 6336	death (Item	23a) (Type, Pr					2101	и Ц	
~	State	-	31. Date filed (Month, Day, Year)	32 Regist	rar's Signatu		112 1	JIUNY	טישו	- 111	J 2101	T- \	
	Registra	r	OCT 13	2011 Denn	n p	. pa	No.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year DONALD 2:57 P.M STEWART OCTOBER GREENSTREET Medical 201 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FRANKLIN SQUARE ROSEDALE BALTIMORE HOSPITAL 5. Social Security Number 6. Sex 1 ፟ M 2 ☐ F If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Birthpiece Country) MD Davs Hours 03/19/1944 212-42-9054 **Director** Usual Residence of Decedent 28a-f shov 10a. State filed within 72 hours after death with the Maryland 10b. County notified at 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits 1 ☐ Yes 2 🗓 No MD BALTIMORE MIDDLE RIVER ō 10e. Street and Numbe 10f. Zip Code the Medical Examiner must be 10g. Citizen of What Country? $\mathcal{GREENSTREET}$, \mathcal{DcnALD} Baltimore, Maryland 21215-0036 items 23a 3810 CLARKS POINT ROAD 21220 USA Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☑ Yes 2 ☐ No
If Yes, Give 0 þ 1 Never Married 2 Married Black, White, etc. 1 Yes 2 No Specify: "natural", Completed 3 Widowed 4 Divorced Specify: Year or Dates WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and 2 should be filed within 7: Health and Mental Hygiene. Iem 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) MASTER CARPENTER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ DONALD GREENSTREET, SR CHARLOTTE BRASHEARS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau VICTORIA GREENSTREET / WIFE 3810 CLARKS POINT ROAD, MIDDLE RIVER, MD 21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MARYLAND VETERANS 10/17/2011 OWINGS MILLS, MD 21. Signature Juneral Service Licenses any in 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death
72 Hou Physician/ DIFFUSE disease or condition resulting in death) BRAIN HOURS Medical Due to (or as a consequence of) Examiner BRAIN DAYS Sequentially list conditions, Examine if any, leading to himselfate cause. Enter Underlying Cause (Disease or linjury requires that the death certificate be executed -tran ELECTRIC DAVS that initiated events resulting in death) Last Due to (or as a consequence of) physician a Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death Month signed by the a d be detached f 2 🗌 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by COPD DIABETES OBSTRUCTIVE SLEEP APNEA page 2 should 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform Yes 2 No 1 Yes 2 No nin 24 hours after death.

the Funeral Director: After this certifica
inpleted filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2. No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify, မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Hospital or Attending 1. Natural (Month, Day, Year) 5 Pending 2 Accident
3 Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number David Tip

State Registrar

DHMH 17 Rev 7/2009

DR. DAVID

31. Date filed (Month, Day,

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

YIP

RES 0000

9000 FRANKLIN SQUARE DRIVE BALTIMORE, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #17&18 Per FH G920 10/14/2011 Jh State of Maryland / Department of Health and Mental Hygiene 0 | 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death GARVIN Month 0 2011 Physician/ 0935 M TRICK Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Prince Gegorge's 12107 Tulip Grove Drive Bowie 8. Date of Birth (Month, Day, Aug • 6 , 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Min. Days Hours 1 2 M 2 1 F Months Georgia °1′937 74 Director 254-54-9425 Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland Director XX Yes 2 ☐ No Prince George's Bowie MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number iral", or items 23a o Examiner must be Funeral 20715 United States 12107 Tulip Grove Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) within 72 hours after death 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Black, White, etc. by 1 Never Married 2 Married 1960-Maryland 21215-0036 1 Yes 2 No Specify: Specify: White "natural" 3 Divorced Completed 1963 Year or Dates Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry United States Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other traumatic event, the once. 華 Patent Office Patent Examiner Be 18. Mother Name (First Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Anastacia McKenna John Calder Garvin , Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12107 Tulip Grove Drive, Bowie, MD 20715 Margaret M. Garvin - Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Metro Crematory 10/12/2011 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Bcall Funeral Home 6512 NW Crain Hwy, Bowie, MD 20715 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Year 5 Other (specify) Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death?
1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 2 No 27. Manner of Death 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 2 Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 29c. License number 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) 151 EFENSE HWY W ICHAEL 31. Date filed (Month, Day, Year)

State

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 0 2011 Medical institution, give stre et and number) **Examiner** 4b. City, Town, or Location of Death County of Death If Under 1 Year / If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **M**M 2 □ F **Director** infant Usual Residence of Decedent 28a-f show 10a. State within 72 hours after death with the Maryland County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Directo 1 Yes 2 No Carca 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 3708 20716 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married þ Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) infant infant infan t infant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, Hother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 🔀 Other (Specify) ins state Signature of Funeral Service Lic 28 taread Adda to my iii Board 655 W. Baltimore Street Wirector. 21201 Baltimore, MD . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) trem Medical Due to (or as a consequence of): Examiner 2.HR 28 410 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that inflicted parts) Examine Due to (or as a consequence of): within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Year Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Completed 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 \(\subseteq \text{Yes} 2 No Certificate: To Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending work' 1 Tes 2 🗌 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier who completed cause of death (Item 23a) (Type, Print) Brown 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Oct. 12^{Day}2011 Bessie Kathryn Hasselhoff 8:00a M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Manor Care Nursing Center Rossville Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
July20,1929 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) 71 200/1939 **Funeral** 1 □ M 2 ⋤ F Months 215-28-9392 82 **Director** Usual Residence of Decedent 28a-f show 10a. State must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MD Baltimore Essex 1 Yes 2 No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23a 35 Berkshire Road 21221 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Examiner Black, White, etc. 1 Never Married 2 X Married þ Yes 2 No Yes, Give BEShie 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker own home 12th Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) することを Frederick George Updegraff i. Page 1 and 2 should be trment of Health and Mertant If item 27 is marke Florence Minnick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Milton Hasselhoff /husband 35 Berkshire Road Baltimore MD 21221 Baltimore, Important: If item any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Moreland Memorial 10/15/11 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funera Ser Licensee 22. Name and Address of Facility 300 MAce Ave. Balto. Connelly Funeral Home of Essex plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or of shock, or heart failure. List only Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Goquentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has the lirector, page 2 s autopsy 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 No ြု 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) this funeral n 24 hours after death.

e Funeral Director: After the oleted filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident
Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated and t 29d. Date signed (Month. Dav. Year) Suse of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		C4-1-	partment of Health and Mertificate of Death	lental Hygiene 201	32599
Physic Med		1. Decedent's Name (First, Middle, Last) Helen P. Hilker		2. Date of Death Month OCL. 11 201	3. Time of Death 1 12:26p ^M
Exami	iner	4a. Facility Name (if not institution, give street and number) Gilchrist Center 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday)	4b. City, Town, or Location of Death Columbia		ward
Funera Director	_	5. Social Security Number 6. Sex 1 M 2 X F 7. Age (In yrs. last birthday, 89 Yrs. Usual Residence of Decedent	Months Days Hours Min.	8. Date of Birth (Month, Day, Year) April5/1922	irthplace (State or Foreign country) MD
Maryland 28a-f shor otified at	Director	Md Baltimore 10c. City, Town or L Rasp	ocation peburg		10d. Inside City Limits 1 ☐ Yes 2 🛣No
with the s 23a or ust be n	Funeral D	10e. Street and Number 4504 Marx Avenue	10f. Zip Code 21206	10g. Citizen of What C	Country?
Nore, Maryland 21215-0036 ge 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at			. Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto F 1 ☐ Yes 2 🛣 No Specify:	Didox, viii	
21215-0036 within 72 hours after giene. er than "natural", o	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) 8th 16a. Decedent's Education (Give infe.) College (1-4 or 5+) H	edent's Usual Occupation e kind of work done during most of workin DO NOT use retired) Omemaker	g 16b. Kind of Busines:	
Maryland 2: 2 should be filed wii th and Mental Hygie 27 is marked other traumatic event, the	To Be	17. Father's Name (First, Middle, Last) Lester Nickies		(First, Middle, Maiden Surname)	
re, Maryl and 2 should t Health and Me tem 27 is mark		571771177	ling Address (Street and Number or Rural 504 Marx Avenue		
Baltimore, bermit. Page 1 and Department of Hea Important: If item any injury or other once.		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify)		ate 20c. Location - City o	or Town, State
Baltimo	j	Vatrue R Pins	Connelly Funer	00 MAce Ave. Ba	
Physician Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	respiratory arrest,	Approximate Interval Between Onset and Death YEAYS	
ificate be executed g physician and as the burial-transit	dical	Cause (Disease or iiĥjury that initiated events resulting in death) Last C			
he death certific y the attending p ched for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Ves 2 No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ves 2 No 9 ☐ Unknown 5 ☐ Unknown 5 ☐ Unknown	Ectopic pregnancy Other (specify)	23d. Date of do Month	elivery Day Year
dS, P.O. quires that the en signed by i		Part II. Other significant conditions contributing to death but not resulting in the Demention	underlying cause given in Part I.	23e. Did tobacco use contribute t	
VITAI MECORAS, ysician: The law require: is certificate has been sig	Completed by	25. Was case referred to medical		autopsy prior to performed?	utopsy findings available completion of cause of
	cate: To Be	examiner? 1 Yes 2 No		e 5 Residence 6 Other (Spe dd. Describe how injury occurred	city) Hospice
Lal or Attending Pl safter death. In Director: After the	l Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, stress building, etc. (Specify)		Bf. Location (Street and Number or Ru City or Town, State)	ural Route Number,
the Hospii ithin 24 hour the Funera	Medical	29a. Certifier (Check 2 Medical Examiner: On the best of my knowledge, death only one) 3 Certifying Nurse Practioner: To the best of my knowledge, 29b. Signature and title of partifier.	stigation, in my opinion, death occurred at the death occurred at the time, date and place,	ne time, date and place, and due to the and due to the cause(s) and manner as	cause(s) and manner stated. s stated.
5 ≥ 6 0		29b. Signature and title of certifier But 1	29c. License number D0060634	29d. Date signed (Mont	th, Day, Year)
かく				Columbia	MD 2104
Sta Registra		31. Date filed (Month, Day, Year) OCT 1 3 2011 3. Registrar's Signature S. Aa	Med	,	

HOFFWAN, JEAN

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			For State Registrar	State of Ma	iryland		tificate of		Mental Hy	/giene Reg. N	2011	3	32600
	Physicia Medi		1. Decedent's Name (First, Middle, Last) Jean	n Elise	Hoff	man			2. Date of Do Month	Da	ay Yea 201	ır	3. Time of Death 9:37A M
and the same	Examir	ner	4a. Facility Name (if not institution, give st.	,				or Location of Deat	h	40	. County of D	eath	
	Funeral		5. Social Security Number 6. Sex		MOZ (In yrs. las		If Under 1 Year	MORE If Under 24 Hrs	8. Date of Bi	rth		/A	ce (State or Foreign
	Director				53	Yrs.	Months Days	Hours Min.		ay, Year)		Country)	
	id iow it	_	Usual Residence of Decedent 10a. State 10b. County		10- 04-	Taura and as			10027				
	arylan a-f sh fied a	Director	MD Balti		TUC. City,	Town or Loc	ation	Dunda	a1k			10d.	. Inside City Limits 1 ☐ Yes 2X No
	or 28	į	10e. Street and Number				10f. Zip Code			10 g . Ci	itizen of What	Country	
	n with	Funeral	3406 Yardley Driv	7e			2122	2		Uni	ited St	ates	3
	r item			Was Decedent Ev Armed Forces?		13. W	Vas Decedent of H Yes, specify Cub	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No o Rican, etc.)	-	14. Race - Al Black, W		
930	s after ral", o Exam	d by	1 ☐ Never Married 2 ☐ Married 3 😾 Widowed 4 ☐ Divorced	1 ☐ Yes 2X N If Yes, Give Year or Dates.	lo	1	☐ Yes 2X No	Specify:			Specify:		ite
2-0	2 hour "natural	Completed	15. Decedent's Educ (Specify only highest grade	cation	$\overline{}$	16a. Deced	ent's Usual Occup	pation during most of wor		16b. F	Kind of Busine		
121	thin 7: ene. than he Me	Com	Elementary/Seconday (0-12)	College (1-4 or 5+		life. DC	NOT use retired,		King	1	ealth C		
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/lan	d be fi	욘	Earl J. Reines						se M. Ma		,		
/an	shoul and h is ma	١.,	19a. Informant's Name/Relationship (Type					and Number or Ru				Zip Cod	(e)
e,	and 2 Health em 27 ther t		Mr. Eric Hoffman 20a. Method of Disposition	(Son)	logi Di			Drive I					222
nor	age 1 ent of nt: If it y or o	i	1 ☐ Burial 2X Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	cen	netery, crem	sition (Name of latory or other place		Date		ocation - City		
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral S ce Licensee	1	LTTT			orp. 10/1			vson, M		
m	e a E Ce	10	milled IV	ein		100	Juda-Ruc 7922 Wis	ss of Facility k Funera, e Ave.	l Home o Dundalk	of Du Maj	ındalk, rvland	21.	2. 2.2.2
			23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused t cause on each line.	he death. I	Do not enter	r the mode of dyir	ng, such as cardiac	or respiratory a	rrest,		Int	oproximate terval Between
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anga de de	Examiner			GT BL									9 days
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98/89	death certificate ne attending phys ed for use as the	Physician/Medio	IF FEMALE:										
	ith cer ittendii or use	ian/	23b. Was decedent pregnant in the past 12 months?	If yes, outcome of	Fetal d	leath 3		су		1	23d. Date of	,	Vers
	ne dea / the a ched f	ysic	1 Yes 2 X No 9 Unknown	4 ☐ Pregnant at t 9 ☐ Unknown	ime of dea	ath 5 ∐	Other (specify) _				Month	Da	y Year
7.	Ine law requires that the tate has been signed by t page 2 should be detach	y Pt	Part II. Other significant conditions contr	ibuting to death but	not resulti	ing in the un	derlying cause gi	ven in Part I.	23e. Did t	obacco i	use contribute	to the c	ause of death?
ds,	en sig	Completed by	Hypertension,	CAD, F	nI				1 🗆	Yes 2	□ No 3 □	Probab	ly 4 WUnknown
Vital Records,	sician: The law require certificate has been si irector, page 2 should I	nple							24a. Was	psy	prior t	o compl	findings available letion of cause of
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NITS	ysicia s certi directo	To Be	eyaminer?	spital: 1 💢 Inpatien	+ 2 N ED	2/Outpationt		ace of Death (Chec				15.3	
5	fter thi		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of injury (Month, Day,	28	Bb. Time of injury	28c. Injury	y at	lome 5 Resi 28d. Describe			есну)	
lon	death.	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be				M 1 🗆	Yes 2 □ No					
DIVISION	- 73		4 Homicide determined	28e. Place of Injury building, etc. (- At home Spec <i>ify)</i>	e, farm, stree	et, factory, office		28f. Location (City or Tox			Rural Roi	ute Number,
- 1	4 hour unera	Medical	29a. Certifier 1 Certifying Physicia (Check 2 Medical Examiner	an: To the best of my	y knowlede	ge, death oc	ocured at the time	, date and place, a	Ind due to the ca	use(s) ar	nd manner as	stated.	(a) and manner states
4	ithin 2 o the I		only one) 3 Certifying Nurse P 29b. Signature and title of certifier	ractioner: To the be	st of my kr	nowledge, de	eath occurred at the	e time, date and pla	ace, and due to th	re cause(s	s) and manner	as stated	d.
	- 3 - 8		Man Add	Lucat	7/120	rdag	29c. License	07730		29d. Da	te signed (Moi	7.	7011
	5		111	pleted cause of dea	th (Item 23	(Type, Pri	BulPle	R. R	altino			7,	20
	Stat	e	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	JI.	DOVIV W	re D	a (1144)	4/2	, ruel	4	202
	Registra		OCT 1 3 2011	Seven	A. 1	gare							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death I. Decedent's Name (First, Middle, Last) 3:20 P.M 2011 Physician/ October 7 Charles D. Horne Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Montgomery Silver Spring 4236 Isbell Street Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) If Unde Months 1 Year If Under 24 Hrs. Age (In yrs. last birthday) Social Security Number Days **Funeral** 72 226-48-5726 1 **X** M 2 □ F **Director** Yrs April 17, 1939 Virginia Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location ms 23a or 28a-f show must be notified at 10a. State Director 1 🗌 Yes 2 🛣 No Silver Spring Montgomery Maryland 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number United States 20906 Funeral 4236 Isbell Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 0 þ 1 Never Married 2 X Married Specify: White 1 Yes 2 X No Specify nan "natural", Medical Exar Year or Dates. 61-63 Completed 3 Divorced 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 27 is marked other thar raumatic event, the M Aircraft / Ship Vice President 12 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) မ Reba Hancock Curtis Horne 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4236 Isbell Street, Silver Spring, Maryland 20906 Sarah K. Horne / Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition Montgomery Crematorium, Inc. permit. Page 1 a
Department of I
Important: If ite
any injury or ot 13, October 1 Burial 2 X Cremation 3 Removal from State Bethesda, Maryland 2011 4 ☐ Donation 5 ☐ Other (Specify) Robert A. Pumphrey Funeral Home, Rockville, Inc 300 West Montgomery Avenue, Rockville, Maryland 20850 21. Signature of Funeral Service Licensee M01619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Malignant neoplasm of head and neck Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Unidentitying Cause (Disease or injury Due to (or as a consequence of): that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) g 🗌 Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 X Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 2 🗌 No Yes 2 X No 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Certificate: To Be examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 X No 28d. Describe how injury occurred 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death nours after death.

neral Director: After the filled in by the funeral 5 Pending 1 X Natural 1 ☐ Yes 2 ☐ No Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 24 hours Medical 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

Baltimore, Maryland 21215-0036

1355 Piccard Drive, Rockville, Maryland 20850 M.D. Registrar's Signatur

- a

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Geoffrey Coleman,

D37142

October 10, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

						nd / D	epartment c Certificate c	of He	alth and N	-		9		321	502
		Physicia Medi		1. Decedent's Name (First, Middle, Last) Gladys Herget						2. Date of D Month	eath Da		ear	3. Time	of Death
į		Examir	ner	4a. Facility Name (if not institution, give street and not institution). 4a. Facility Name (if not institution, give street and not institution). 4b. Facility Name (if not institution, give street and not institution). 4c. Facility Name (if not institution, give street and not institution). 4c. Facility Name (if not institution, give street and not institution).	HOSPITAL BALTIMORE					8. Date of Bi	irth	c. County of			
		Director		215-16-6211 1 M 2 X Usual Residence of Decedent					Hours Min.	July 2	Year)	.921	Coun	ry)	or Foreign unk
		2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	Funeral Director	10a. State 10b. County MD Baltimore 10e. Street and Number	10c. Cit		or Location altimore 10f. Zip Coo	de		10g. Citizen of W				1 🗆 Y	City Limits es 2X No
		th with t ms 23a must be	ıneral	1113 Circle Drive				21	227			US.	Α		
	9800	urs after dea ural", or ite Il Examiner	þ	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 1 Yes, 6 Year or	Forces? es 2 No Give	unk	13. Was Decedent of If Yes, specify C			ecity Yes or No Rican, etc.)		14. Race - Black, Specify:		etc.	1
	21215-(vithin 72 hou iene. r than "nat the Medica	Completed	15. Decedent's Education (Specify only highest grade complete Elementary/Seconday (0-12) unk College	e <i>d)</i> e (1-4 or 5+)	(Decedent's Usual Oc Give kind of work do ife. DO NOT use retii	ne durii	n ng most of work	unk ^{ing}	16b. k	(ind of Busir	ess Ind	lustry	unk
	Maryland 21215-0036	should be filed within and Mental Hygiene. 'is marked other tha 'aumatic event, the l	To Be	17. Father's Name (First, Middle, Last)			un		. Mother's Nam						unk
	, Mar	nd 2 shou ealth and m 27 is m		19a. Informant's Name/Relationship (Type, Print) St. Agnes Hospital		19b.	Mailing Address (Stra 100 S. Cat	eet and	Number or Rura AVenue]	al Route Numb 3altimo	er, City or	MD 2	Î 222	ode)	
HACEL	Baltimore,	permit. Page 1 and 2 Department of Health Important: If item 23 any injury or other to		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal fro 4 □ Donation 5 ☑ Other (Specify) in s	om State		Disposition (Name of crematory or other			Date	20c. L	ocation - Ci	y or To	wn, State	
	Balt	permit Depart Import any inj		21. Signature of Superal Service Licensee ROTALE S. Wade	Nicector	٠	22 Name and Ad State A		f Facility Omy Boa MD 21		W. E	Baltim	ore	Stre	et
ys M		Physician/ Medical Examiner		resulting in death) Due t	each line.	FU	NKNOWN			or respiratory a	rrest,		-	Approxim Interval B Onset and	etween d Death
GLADYS	0	te be executed nysician and ne burial-transit	ical Examiner	Due to (or as a consequence of): Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of):											
	Box 6876	death certifica ne attending pl ed for use as t	Completed by Physician/Med	FFEMALE: 23c. If yes, outcome of pregnancy 1								23d. Date o		ry Day	Year
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	Division of Vital Records,	To the Pospital or Attending Physician: The law requires that the within 24 hours after death. Of the Funeral Director. After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach.		CHRONIC ATRIA	DEMENT	1A			-	24a. Was auto perfe 1 □ Yes	psy ormed2	prio dea	r to cor h?	sy finding npletion of	s available cause of
	Vital	nysicians is certific director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital:	Inpatient 2	ER/Outp	1	Othor	of Death <i>(Check</i> I □ Nursing Ho		idence 6	Other (S	Specify)		
	on of	nding Pt ath. r: After the re funeral	Certificate:		te of injury onth, Day, Year)	28b. Tin inju		njury at		28d. Describe			,)		
	Division	To the Hospital or Attending Physician: The law within 24 Jours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2.8		3 Suicide 6 Could not be 4 Homicide determined 28e. Plau buil	lding, etc. (Specify)	")	n, street, factory, offic			28f. Location (City or Tox	wn, State,)			nber,
	:	the Hosp hin 24 hou the Funei npleted fil	Medical	29a. Certifier 1 Certifying Physician: To the conly one) 3 Certifying Nurse Practione	asis of examination	n and/or i	nvestigation, in my or	pinion, d	eath occurred at	the time, date a	and place	, and due to	the cau	se(s) and n	nanner stated.
•		o vit		29b. Signature and title of certifier Sun calata M			, ,	25	181			te signed (M			
	ja:			30. Name and address of person who completed ca 900 \$ CATON AVE 31. Date filed (Month, Day, Year) OCT 1 3 2011	use of death (Item	23a) (Ty	pe, Print) MARY	uga	10 ala	229					
		Stat Registra	e	31. Date filed (Month, Day, Year) OCT 1 3 2011	Registrar's Signa	ure	and								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 32603 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 2011 Evelyn Harmon October 6, 12:10 AMM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Rockville Montgomery Casey House Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth Dec 11, 1947 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 💢 F Months Davs Min Maryland Director 63 212-54-6870 Usual Residence of Decedent 28a-f show 10a. State 10b. County the Maryland ä 10c. City, Town or Location 10d. Inside City Limits Director "natural", or items 23a or 28a-f s edical Examiner must be notified 1 Yes 2 No MD Montgomery Rockville 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral I 908 Lincoln Street 20850 USA Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: white Completed 3 Widowed 4 X Divorced Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 bookkeeper/manager 0 construction Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Evelyn Easom 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2100~SE~51st~Street~Gainesville,~FL~32641Darla Harmon/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other placel 4 □ Donation 5 🕅 Other (Specify) in state 21. 23 Physician/ Medical **Examiner** Se if a ca ca tha res Physician/Medical Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed IF F 23b After this certificate has been signed by the a funeral director, page 2 should be detached it Par Completed by 25. Certificate: To Be

Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica

21. Signature of Superal Service License Rolle 1	ade, Director	1	Nate and Address Space Street					
23a. Part 1. Inter the disea e, or comp shock, on leart failure. List only on	lications that caused the death. Do	Baltimore, MD not enter the mode of dying, such		rest,	Approximate			
Immediate Caus Est only on disease or condition resulting in death)	a. lung cancer Due to (or as a consequence				Interval Between Onset and Death			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or linjury that initiated events resulting in death) Last	Due to (or as a consequence Due to (or as a consequence Due to (or as a consequence							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal deat 4 Pregnant at time of death 9 Unknown	n 3 Ectopic pregnancy 5 Other (specify)		23d. Date of de Month	livery Day Year			
Part II. Other significant conditions co COPD	ntributing to death but not resulting	in the underlying cause given in F		obacco use contribute to	the cause of death?			
			24a, Was autop perfo 1 Yes	osy prior to death?	topsy findings available completion of cause of			
25. Was case referred to medical examiner? 1 Yes 2 No	lospital: 1 Inpatient 2 ER/Ou	Othor	Death (Check only one) Nursing Home 5 Resid	Nanca 6 NOther (Space	Homes.			
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury 28b.	Fime of njury at work? M 1 ☐ Yes 2	28d. Describe h	now injury occurred	any) is Spires			
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, fa building, etc. (Specify)	rm, street, factory, office	28f. Location (S City or Tow		nd Number or Rural Route Number, a)			
(Check 2 L Medical Examin	cian: To the best of my knowledge, er: On the basis of examination and/o	r investigation, in my opinion, deatl	occurred at the time, date a	nd place, and due to the	cause(s) and manner stated.			
29b. Signature and title of certifier	'ei - ((1)	29c. License numbe	er	29d. Date signed (Monti	n, Day, Year)			
30. Name and address of person who co	mpleted cause of death (Item 23a) (son CRNP 600 Mun	71 . ,		October 6,	2011			
31. Date filed (Month, Day, Year) OCT 1 3 2011	A resistrar's Signature	hare						
	OI	RIGINAL						

State Registrar

Medical

29b

30.

31.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Ma	ıryland / [-	rtment of H tificate of D		nd Mental I	Hygie Reg	201	1	32604
			Registrar 1. Decedent's Name (First, Middle, Las	(First, Middle, Last) 2. Date of									3. Time of Death
Physician/ Medical William Albert Hou							ston		Octo	ber	12, 201		4:35 A ^M
Ö	4a. Facility Name (if not institution, give street and number) 4503 Breidenbaugh Lane 4504 Glen Arm										4c. County of Balt:		•••
	Funeral		4503 Breidenbaugh 5. Social Security Number 6. S		(In yrs. last birtl	hday)	If Under 1 Year Months Days	If Under 24 Hours		8. Date of Birth (Month, Day, Year)			lace (State or Foreign
	Director		213-38-7986 Usual Residence of Decedent	X M 2 □ F	70	Yrs.	Months Days	riouis	Dec.			Mar	yland
	and show	į	10a. State . 10b. County		10c. City, Town	or Loc	ation					10	Od. Inside City Limits
	Maryl 28a-f otifie	Director	Maryland Baltimo	re	Gler	n Ar							1 ☐ Yes 2X No
	ith the 23a or st be n	ral	10e. Street and Number	Tano			10f. Zip Code 2105	:7		10g	g. Citizen of Wha		try?
	eath w	Funeral	4503 Breidenbaugh 11. Marital Status	12. Was Decedent Ev	er in U.S.	13. W			n? (Specify Yes or	No-	14. Race -	America	
21215-0036	s filed within 72 hours after death with the Maryland tal Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 【 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 🔀 N If Yes, Give Year or Dates.	40	13. Was Decedent of Hispanic Origin? (Spetif Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:			Puerto Ricari, etc.		Specify:	White, e	ite
15-(72 hou n "natu ledica	Completed	15. Decedent's E (Specify only highest gro		16a.	(Give ki	ent's Usual Occupa ind of work done d	ation <i>uring most c</i>	of working	16	b. Kind of Busir	ess/Ind	ustry
212	ed within Hygiene.		Elementary/Secondary (0-12)	College (1-4 or 5-	-) I		NOT use retired) pecialis	t		ŀ	Hospital	L	
	be filed v ental Hyg ked othe ic event ,	o Be	17. Father's Name (First, Middle, Last)		•			18. Mother	's Name (First, Mic				
Maryland	2 should be file th and Mental I 27 is marked o traumatic eve	2	Samuel Samuel	Hopkins		oust			Katherin	-	Louis		Bennett
	~ ~ ~ =		19a. Informant's Name/Relationship (T				g Address (Street a Breidenb						
altimore,	ge 1 and 2 st of Health		20a. Method of Disposition 1 Burial 2 X Cremation 3		20b. Place of	f Dispos	ition (Name of atory or other place		Date		c. Location - Ci		
tim	t. Page tment tant: I		4 Donation 5 Other (Special	y)	Hillto	p S	ervice C	orp.10	-13-2011	_ _T	Towson		ryland
Bal	permit. Page Department or Important: If any injury or once,			gan		1	Name and Addres	Road	Towsor	, Ma	n Funera aryland		ome, Inc. 1204
Г			23a. Part 1. Enter the disease, or com shock, or heart failure. List only o	plications that caused ne cause on each line.					ardiac or respirato	y arrest,			Approximate Interval Between Onset and Death
ine	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. Ade NO (ALCI W		A	WUS				+	Onset and Death
And the second	Examiner	,	Construction III. I link nor all kings	b	consequence o	21/1.							
	ol sit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequence o	of):							
	ecuter and al-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a	consequence o	of):						+	
0	cate be executed physician and the burial-transit	edical		d								\perp	
68760	rtificate ing phy e as th	/Med	IF FEMALE:						-				
Box 6	hat the death certific ed by the attending p detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at 9 Unknown	n 2 ☐ Fetal death 3 ☐ Ectopic pregnancy t at time of death 5 ☐ Other (specify)					23d. Date of c			ny Day Year
s, P.O.	v requires that th been signed by should be detad	by	Part II. Other significant conditions of	ontributing to death bu	t not resulting i	n the un	nderlying cause giv	en in Part I.					e cause of death?
Division of Vital Records,	> 00	Completed								Vas an lutopsy performe Yes 2	prio dea	r to con	osy findings available inpletion of cause of
tal	cian: T ertifica ector, p	Be C	25. Was case referred to medical examiner?	Honeitel				•	(Check only one)				
Ţ	Physion this control din	: To	1 ☐ Yes 2 ☐ No 27. Manner of Death	Hospital: 1 Inpatie 28a. Date of injury	nt 2 ER/Ou	tpatient	3 DOA Othe	4 L Nurs	sing Home 5 C		e 6 Other (Specify)	
o uc	nding ath. 1. After e fune	icate	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day,		njury	work'		i	DE HOW I	injury occurred		
ivisio	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director, After this certificate ha completely filled in by the funeral director, page:	Certificate:	3 Suicide 6 Could not b 4 Homicide determined			rm, stre	et, factory, office			on (Stree Town, S	et and Number of State)	r Rural	Route Number,
	Hospital 24 hours Funeral I etely filled	Medical	(Check 2 Medical Exami	sician: To the best of n ner: On the basis of ex- se Practitioner: To the	amination and/or	r investi	gation, in my opinio	n, death occ	urred at the time, d	ate and p	place, and due to	the cau	ise(s) and manner stated.
	To the within To the	2	only one) 3 ☐ Certifying Nurs 29b. Signature and title of certifier	C Tractitorier. To the	C C C C C C C C C C C C C C C C C C C	meage,	29c. License		- 1		. Date signed (A		
			Michael .	pers V	<i>J</i>)		100	210	15.8	0	CTOBEN	12	, 6011
			Name and address of person who of	completed cause of de	ath (Item 23a) (I	Type, Pr	200, Y	724	Csupher	DB	10 d. B	AZT	7 1236
	Stat Registra		OCT 1 3 2011	32. Regurar	Marke						<u>.</u>		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

mend #5 Per FH G920 10/24/2011 JH
State of Maryland / Department of Health and Mental Hygiene for State Registrar 32605 Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) Day 2011 Physician/ October 12:15 AM Ann Muncaster Rice Jett Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery 9. Birthplace (State or Foreign Country) Washington, D.C If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) June 2, 1923 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 X F 88 June Director 219-12-4531 Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location must be notified at with the Maryland Director 1 ☐ Yes 2 🕅 No 28a-f Maryland | Montgomery Germantown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ŏ Funeral items 23a 14147 Darnestown Road 20874 United States death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 12. Was Decedent Ever in U.S. 1100/1/01 11. Marital Status Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc ö 1 Never Married 2 Married þ Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White "natural" Completed 3 XWidowed 4 Divorced event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) 5+ Public Schools System Educator Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental His marked o 2 injury or other traumatic Millard Lee Rice, II Helen Muncaster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 202/ 209 Maple Ave., Washington Grove, MD 20880 William L. Jett/Son .0. Box20a. Method of Disposition 20c. Location - City or Town, State 20b. Uniformedo Services Date October 3, University of the Health Sciences ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 Other (Specify) Bethesda, Maryland 2011 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home, Rockville, Inc. 300 W. Montgomery Ave., Rockville, Maryland 20850 Harau has M01530 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final Physician/ Acute Arrhy Thmia disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): ohysician and the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for Month Day 5 Other (specify) Pregnant at time of death signed by the a d be detached f 9 Unknown Part II. Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner?
1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA this 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes filled in by the funeral 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certificate: Director; After injury 1 Natural 5 Pending 2 \square No after death. Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Medical Xcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner; On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse/Practioner; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 68488 October 01,2011 MD who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person Medical Car Dr Rockville, MD 9901 m SSE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

0015

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 32606 State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 11, Robert Krasnodemski Oct. 2011 Harry 7:23 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 8002 Kavanagh Road Dunda1k Baltimore Co. 5. Social Security Number 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Nov. 20,1946 **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Hours Director 218-48-2863 1**X** M 2 □ F 64 Maryland Usual Residence of Decedent show 10a, State with the Maryland Director 10b. County 10c. City, Town or Location 10d. Inside City Limits notified 28a-f 1 ☐ Yes 2 X No Dunda1k Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? must be Funeral permit. Page 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hyglene. Important: If item 27 is marked other than "--- any injury or other traumati-items 23a 8002 Kavanagh Road 21222 United States 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 No
If Yes, Give þ 1 X Never Married 2 Married 1 ☐ Yes 2 No Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Retail Sales 7 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Elizabeth B. Jackewitz ဂ္ John Anthony Krasnodemski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8002 Kavanagh Road Dundalk, Maryland 21222 Ms. Kathy Breighner(Friend) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 T Cremation 3 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) 10/13/2011 Towson, Maryland Hilltop Service Corp. uneral Service Licensee 21. Signatur 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk,
7922 Wise Ave. Dundalk, Maryland 21222 23a. Part 1. Enter the disease, or complications the shock, or he to failure. List only one cause on r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death disease or condition resulting in death) Medical

Ph sician/ Examiner

burial the signed by d be detact page 2 filled in by completely

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Medical Examiner	Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		
Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Uyes 2 Vo g Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown	23d. Date of delivery Month Day Year
Completed by Pr	Part II. Other significant conditions con Conges froe Lung Canc	Artibuting to death better resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1
g	25. Was case referred to medical examiner?	26. Place of Death (Check	only one)
0	1 Yes 2 INO	ospital: 1	ne 5 Residence 6 Other (Specify)
ricate:	27. Manner of Death 1	One Date of injury	8d. Describe how injury occurred
al Certi	3 ☐ Sulcide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
Medic	(Check 2 Medical Examile	cian: To the best of my knowledge, death occurred at the time, date and place, and process of examination and/or investigation, in my opinion, death occurred at the time, date and place the process of the best of my knowledge, death occurred at the time, date and place.	the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

timore MD 21224

2011

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State Registrar

hin 24 hours after death. the Funeral Director: Al

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Signature and t

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pleted cause of death (Item 23a) (Type, Print)

MD

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 32607 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Ann 6:13PM 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Cherlstown Core Centr Baltimore, Md 21228 Baltimire Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🔀 F Hours 89 Maryland **Director** 215-42-7526 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits Catonsville Baltimore MD 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21228 USA 719 Maiden Choice Lane, HR 612 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc þ 1 Never Married 2 X Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Private School 12 Nurse, RN Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Marie F. Read Andrew B. Linhard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 2703 Paper Mill Road, Phoenix, Maryland 21131 Joseph F. Powers / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Donation 5 Other (Specify) New Cathedral Cemetery 10/12/2011 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 WIlkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph sician/ Multi-interct dementia disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** SCVO Sequentially list conditions, if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events The law requires that the death certificate be executed burial-trar resulting in death) Last Due to (or as a consequence of): physiciar Physician/Medical P.O. Box 68760 as attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Pregnant at time of death 5 Other (specify) Month Dav Vear 2cm No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, cate has been signated by page 2 should by Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy safter death.

Director: After this certificate performed?

1 Yes 2 No 2 🗌 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 ☑ No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4⊠Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending 1 Tes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M. Butters crop R092382 10-11-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Sid

Maiduncherce Lone Baltimere, Md 21228 Core Centr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 26 per med cert G920 10/13/11 dk
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 8 Physician/ 0 gonth 40A M 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 300 Salon Dr. Apt 202 Baltimore Co. Reisterstown 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 XM 2 - F Hours 0774471940 Maryland Director 220-36-2256 71 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at should be filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director N/A MD Baltimore tx Yes 2 □ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1208 Ashburton St. 21216 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black. White, etc. 1 Never Married 2 A Married Completed by 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", Specify: Black 3 Widowed 4 Divorced Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) nt of Health and Mental Hygiene.
If item 27 is marked other than or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) truck driver Odorite Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Manuel Mason Helen Gross 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Gloria Mason(wife) Catherine St., Winsall, NC 27985 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) on-site Crematory 09/26/11 Baltimore, MD 21. Signature of Funeral Service License JOSEPHAHES Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD MD 21217 23a. Part 1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner Due to (or as a cor attending physician and Due to (or as a consequence of) resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year Yes 2 No 9 Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕦 Unknown funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 No After this certificate 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Hestoence 6 1 Other (Specify) residence Hospital: 2 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 Pending ☐ Accident☐ Suicide 1 Yes 2 No neral Director; A Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Flural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral D

completed filled i Medical 12 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signal 30. Name an State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

December Name Print, Assoc, Land Macket December Name Print, Assoc, Land Macket December Name Name December Name Dec				State	State of Marylar	nd / Department o			1 1	00000	
The country of the co				Registrar		Certificate o	f Death	2. Date of Deat	th	3 2 5 0 9 3. Time of Death	
Procedure Proc		Medi	cal	Kichard		Macker	eth		Day 2 Year 2011	0340 M	
220-36-1285 20 mg 19 mg	ر الم			The Johns Ho	PKINS HOS	Spital Bal	timore	city	N/A		
Second Part		Director		220-36-1285 ₁ X	44.0 DE	Months Day		. (Month, Day,	Year) Cour		
12 Years Millwright Steel Indust Steel Indu	ryland	-f shov ied at	cto	10a. State 10b. County		y, Town or Location				10d. Inside City Limits	
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12 Years Millwright Steel Indust Steel Indu	th with	ns 23a must b	neral	2801 8th Street		2	1219				
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Physician Medical Examiner Physician Medical Examiner To graph and the physician of the p	Dan permit Depar	Impor any in once.		21. Signature of Funeral Service Licensee							
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State Registrar 31. Date filed (Month, Day, Year) OCT 1 3 2011 32. Registrar's Signature A. Aparlo	R	State Registra	~	31. Date filed (Month, Day, Year)	32. registrar's Signatu	J. parks		ANOUG 21	1,170 (1111101C	(VII), 4120T	

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Director

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OCTOBER 7, 2011

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in/	1. Decedent's Name (First, Middle, Last) Mildred	Elmira	Mos	sel		2	2. Date of Death Month Oct.	Day	Year 011	3. Time of Death 8:50 A M	
ner	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death								y of Death		
	Stella Maris Hospice Cen 5. Social Security Number 6. Sex 7. A	ter ge (In yrs. last bil	thdav)	Timor If Under 1 Yea		24 Hrs. 8	B. Date of Birth	Ba	1timo	re lace (State or Foreign	
		99	Yrs.	Months Days	Hours	Min.	(Month, Day, Sept.4,		Count	sylvania	
ip	10a. State 10b. County 10c. City, Town or Location								1	0d. Inside City Limits	
Direc	MD Baltimore Edgemere									1 ☐ Yes 2X No	
Funeral Director	10e. Street and Number 7306½ Hughes Avenue		10f. Zip Code 10g. Citizen of What 21219 United S							*	
by Fu	11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 22	?	If	Vas Decedent of Yes, specify Cul	an, Mexicar	n, Puerto Ric	y Yes or No- can, etc.)		ce - America ick, White, e		
Completed by	3 X Widowed 4 □ Divorced If Yes, Give Year or Dates.		1	☐ Yes 2 🛣 N	o Specify:			Specify	v: WI	nite	
mple	15. Decedent's Education (Specify only highest grade completed)		(Give k	ent's Usual Occu ind of work done ONOT use retired	during most	t of working		16b. Kind of E	Business/Ind	dustry	
ပ္	Elementary/Secondary (0-12) College (1-4 or 8 Years			ory Wor				Chem	ical (Company	
To Be	17. Father's Name (First, Middle, Last) Unkn •				1		First, Middle, M Mary No		ne)		
- 15	19a. Informant's Name/Relationship (Type, Print)	191	o. Mailin	g Address (Stree					State, Zip C	code)	
	Stacy Percoski(Granddaughter) 5730 Meyerfield Ct. Eldersburg, MD 21784										
	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	cemete	ery, crem	sition (Name of latory or other plate Mem.		10/11		Elkric	-	_{wn, State} Maryland	
	21. Signature of Funeral Service Licensee		²² I	Name and Addr Ouda - Ruc '922 Wis	ess of Facilit K Fune e Ave	ral H Dund	Nome of	Dunda:	1k, Ir 1 212	nc. 222	
	23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each lir		Approximate Interval Between								
	Immediate Cause (Final disease or condition resulting in death) CONGESTIVE HEART FAILURE Due to (or as a consequence of):									Onset and Death	
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Exar	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as	a consequence	of):								
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Completed by Physician/M	in the past 12 months?	2 Fetal deat at time of death		Ectopic pregnar Other (specify)	су				ate of delive	rry Day Year	
y Pr	Part II. Other significant conditions contributing to death	but not resulting	in the ur	nderlying cause o	iven in Part I	ī.	23e. Did toba	acco use cont	tribute to the	e cause of death?	
ted t							1 ☐ Yes	s 2 🗆 No	3 🗌 Prob	ably 4 X Unknown	
mple							24a. Was an autopsy perform	/	Were autop prior to con death?	sy findings available inpletion of cause of	
Be Co	25. Was case referred to medical			26.1	Place of Deat	th (Check on	1 🗆 Yes 2		1 🗌 Yes	2 🗆 No	
၉		ient 2 ER/O	utpatient	Tot	or:		<u> </u>	nce 6 🗶 Oth	er (Specify)	HOSPICE	
	27. Manner of Death 1		Time of injury	28c. Inju wo M 1	ryat k?]Yes 2 □		d. Describe how	v injury occum	red		
Medical Certificate:		ury - At home, fa c. (Specify)	ırm, stre		res 2 🗆	-	Location (Stre		er or Rural	Route Number,	
ical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									d.	
	(Check only one) 3 M Certifying Nurse Practitioner: To the 29b. Signature and title of certifier	examination and/o	or investig	gation, in my opir death occurred at	on, death oc the time, dat	curred at the	e time, date and and due to the	place, and du cause(s) and r	e to the cau manner as st	se(s) and manner stated. tated.	
	Tune lea Wh	te CI	en.	P 29c. Licen:	1 2 7	4-	74 29	d. Date signe	a (ivionth, D	yay, rearj	
	30. Name and address of person who completed cause of c JUNECIA WHITE, CRNP 2300	DULANE	Y VA	LLEY RD	. TIM	ONTIM	, MD 21	/			
e r	31. Date filed (Month, Day, Year) OCT 1 3 2011	ar's Signature	bark	1							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Monte- Moluski nthi October 3:30 8 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death city pspital topkins Ihmorz 6. Sex . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) (Month, Day, Year) Davs Hours 212-94-2601 **Director** 1 □ M 2**XX**F Jul. 15, 1965 New Jersey Usual Residence of Decedent 46 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. 10a. State must be notified at 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits MD Anne Arundel Crofton 1 ☐ Yes XX No ь 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a 1118 Charing Cross Drive 21114 U.S.A. items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, þ 1 Never Married 2 Married Black, White, etc. "natural", or Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 ☑ No Specify Completed 3 Widowed 4 X Divorced Specify: White Year or Dates of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Project Manager Defense Systems Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Daniel Monte Sharon Whitmore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Monte-Kegley - Mother 506 Quincy Hall Dr., Myrtle Beach, SC 29579 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State pa of Disposition (Ivaline v. netery, crematory or other place)
Paul's Lutheran 10–15–2011 Fulton
Paul's Lytheran 10–15–2011 Fulton
Paul's Lutheran 22. Name and Advess of Facility Beall Funeral Home Date Department of Important: If it any injury or c Burial 2 Cremation 3 Removal from State 5 Other (Specify) Fulton, Maryland Service Licer eral 6512 NW Crain Hwy, Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Ph. sician/ Hepato cellulas disease or condition resulting in death) Carcinom Medical as a consequence of Examiner Sequentially list conditions if any, leading to immediate
Cause (Disease or injury Due to (or as a consequence of): Exami the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? signed by the at Id be detached fo Pregnant at time of death Month Day 2 X No 1 Yes 2 7 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has Is eral Director: After this certificate has filled in by the funeral director, page 2. prior to completion of cause of death? autopsy performed? Yes 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 🗷 No ျ 1 Yes Other: 1 🗖 Inpatient 2 🗌 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending work Accident
Suicide Investigation 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

State

Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Registrar's Signatu

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31. Date filed (Month, Day,

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Baltimore MD 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 32612 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 2011 11:37 October | Louis N. Medgyesi-Mitschang Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Montgomery Bethesda Suburban Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number **Funeral** (Month, Day, Days Hours Min Months 1 XM 2 ☐ F Yrs 1940 Hungary **Director** 500-46-7240 71 March Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10b. County 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medic w Examiner must be notified at Director 1 Yes 2 X No Potomac Maryland | Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral United States 20854 10013 Ormond Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S 11. Marital Status Black, White, etc. Armed Force 1 ☐ Yes 2 XNo If Yes, Give þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: White "natural", 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 h and Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Scientific Research Executive 5+ Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Louis P. Medgyesi-Mitschang Susan B. Lahny 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) and 2 s Health a 10013 Ormond Road, Potomac, Maryland 20854 Susan B. Medgyesi-Mitschang (Mother) injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) October 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2011 Gate of Heaven Cemetery 21. Signature of Funeral Service Lice Robert A. Pumphrey Funeral Home, Bethesda—Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814 M01530 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Coronary Artery Disease disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Live Birth 2 Fetal death Ectopic pregnancy in the past 12 months? Month Day Year Por Pregnant at time of death Unknown the detached 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Hypertension ledgyesi-Mitschang, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗆 No Yes 2 💢 N To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director, I 26. Place of Death (Check only one) 25. Was case referred to medical Be Hospital 1 X Yes 2 □ No 1 Inpatient 2 X ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 28c. Injury at 27. Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred Certificate: (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical XCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie atel Layariti 10052586 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8600 Old Georgetown Road, Bethesda, Maryland 20814 Jayariti Pate1 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

OCT 1 3 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 9^{Day} Physician/ William W. No11 201T Oct. [™] σ00:40 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Co. Dunda1k 222 Robwood Road Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday, 1 Year If Under 24 Hrs 8. Date of Birth **Funeral** Months Hours 11/05/1948 219-50-6357 62 Director 1 XM 2 F 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits Medical Examiner must be notified at Director 1 Yes 2 No Baltimore Baltimore 10e. Street and Number 10f. Zip Code o 10g. Citizen of What Country? Funeral 23a U.S.A. 21222 222 Robwood Road permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items: any injury or other traumatic event, the Medical Examiner musonce. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian, Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 X Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 Yes If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Shipping and Receiving Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ Walter Noll Ardell Greenawald William Betty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2804 List Avenue, Baltimore, Harold K. Reidnauer, Brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 10/12/2011 Towson, Maryland Hillton Svc.Corp Leonard J. Ruck, Inc. Signature of Funeral Service Licensee 22. Name and Address of Facility 5305 Harford Road, Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last physician by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery for in the past 12 months?
1 Yes 2 No Month Dav Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signe page 2 should be 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed Yes 2 1 Tes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) the funeral 27. Manne of Death 28c. Injury at work?
1 Yes 2 No 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending Accident Investigation Suicide 6 Could not be filled in by Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of Day, Year) 29c. License number 29d. Date signed (Month erses who completed cause of death (Item 23a) (Type, Print) 30. Name and address of Baltimore Maryland 6730 Holabird Avenue Dr. Ali Sanai, MD

Registrar

State

31. Date filed (Month, Day, Year)

3 2011

. Registrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Maryland / De C	partment of He ertificate of De			2011	32614	
	Physici: Medi		1. Decedent's Name (First, Middle, Last) David B. Newlin				2. Date of Death Month September		3. Time of Death 1:33 AM M	
1	Exami		4a. Facility Name (if not institution, give stre	eet and number)	4b. City, Town, or L		September	4c. County of Dea		
1) Enilogia	p	Gilchrist Hospice 5. Social Security Number 6. Sex	7 Aga (la una la chialada		COlumbia		Howard		
	Funeral Director		,	7. Age (In yrs. last birthda 58 Yrs	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth July 10,	^{9. Bi} 1953 Into	rthplace (State or Foreign	
	land show dat	힏	10a. State 10b. County	10c. City, Town or	Location				10d. Inside City Limits	
	Mary 28a-f otifie	irec	MD Howard	CC	Olumbia				1 ☐ Yes 2X No	
	ith the 3a or t be n	la D	10e. Street and Number		10f. Zip Code	010/5	10g	. Citizen of What C	•	
	eath w tems?	Funeral Director	5157 Scarecrow Co	. Was Decedent Ever in U.S. 1:	3. Was Decedent of Hisp	21045	cify Yes or No-	14. Race - Am	JSA	
920	72 hours after death with the Maryland n "natural", or items 23a or 28a-f show ledical Examiner must be notified at	Completed by 6	1 ☐ Never Married 2 🙀 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 X No If Yes, Give Year or Dates.	If Yes, specify Cuban, 1 ☐ Yes 2 🔀 No	Mexican, Puerto F	Rican, etc.)	Black, Whi		
5-0	2 hour "natur	plete	15. Decedent's Educi (Specify only highest grade	ation 16a. De	cedent's Usual Occupati		16	b. Kind of Business	Industry unk	
2121	within 72 giene. er than , the Me		Elementary/Seconday (0-12)		re kind of work done dur DO NOT use retired) research		g			
nd	be filed v ental Hyg ked othe ic event,	Be c	17. Father's Name (First, Middle, Last)	3,			(First, Middle, Maid	den Surname)		
ryla	should be and Ment is marke raumatic	2	George William Ne					hel Mehai		
Ma	d 2 sho alth an 127 is a		19a. Informant's Name/Relationship (<i>Type</i> , Kathy Kamo/spouse	1 55. 1018	illing Address (Street and 57 Scarecro					
ore,	ie 1 and t of Heal If item or other		20a. Method of Disposition 1 Burial 2 Cremation 3 Rei	20b. Place of Dis	position (Name of rematory or other place)			c. Location - City or	Town, State	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical ODE."		4 X Donation 5 Other (Specify)			1				
Ba	permit. Departrimonta amy inju		21. Signatur o Engral Service Licen	de Virector	22. Name and Address of State Anato	omy Board MD 2120	655 W.	Baltimore	Street	
			23a. Part 1 Enter the disease, or complica shock or heart failure. List only one c Immediate Cause (Final		nter the mode of dying,	such as cardiac or	respiratory arrest,		Approximate Interval Between	
-	Physician Medical		disease or con mon resulting in death)	Due to (or consequence of):	ER				Onset and Death MONTHS	
	Examiner	<u>_</u>	Sequentially list conditions, b.							
	rted d insit	Examiner	if any, leading to immediate Cause (Disease or iinjury	Due to (or as a consequence of):						
	e execuian and	EX:	that initiated events c resulting in death) Last	Due to (or as a consequence of):						
760	icate be executed I physician and s the burial-transit	edical	d							
89	certif nding use a	M/ME	Los. Has accedent pregnant	If yes, outcome of pregnancy				23d. Date of de	livery	
Box	requires that the death been signed by the atte should be detached for i	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live Birth 2 Fetal death 3 4 Pregnant at time of death 5 9 Unknown	Other (specify)			Month	Day Year	
9. O	requires that the de been signed by the should be detached		Part II. Other significant conditions contril	outing to death but not resulting in the	underlying cause given	in Part I.	23e. Did tobaco	co use contribute to	the cause of death?	
ds,	quires en sigr ould be	Completed by	ATRIAL FIBRILLATIO	N			1 🗶 Yes	2 🗆 No 3 🗆 P	robably 4 🗆 Unknown	
ວ	aw as	nple					24a. Was an autopsy	prior to	topsy findings available completion of cause of	
¥ ,	n: The la ficate ha		25. Was case referred to medical				performed	l? death? No 1 ☐ Yes	s 2 🗆 No	
<u> </u>	sicia certi irecto	ω	examiner? 1 \(\sum \text{Yes} 2 \) \(\text{No} \) Hosp	pital:	0.11	of Death (Check of			110.00	
5	y Phy er this eral d	<u>မ</u> မ		1 Inpatient 2 ER/Outpati 28a. Date of injury 28b. Time	ent 3 L DOA		e 5 Residence	•	ity) HOSPICE	
<u>.</u>	eath. or: Afte the fun	ficat	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year) injury	work?	s 2 🗆 No	d. Describe flow if	ijury occurred		
DIVISION	al or Att s after d al Direct ed in by t	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28	3f. Location (Street City or Town, St	eet and Number or Rural Route Number, State)		
	To the hospital or Attending Physician: The within 24 hours after death. To the Funeral Directors After this certificate he completed filled in by the funeral director, page.	ledical	(Check 2 ☐ Medical Examiner:	To the best of my knowledge, death	estigation, in my opinion, o	death occurred at the	ne time date and nla	ace and due to the	rause/s) and manner stated	
ř	Vithin Vomp	Σ	only one) 3 \(\subseteq\) Certifying Nurse Pr 29b. Signature and title of certifier	actioner: To the best of my knowledge	, death occurred at the tir 29c. License nu			se(s) and manner as Date signed (Month		
			1 10	Chr	264	1395		PTEMBER		
			30. Name and address of person who comp	leted cause of death (Item 23a) (Type,	Print)	PALIE	MAIA. 11	n 21041	4	
	State		31. Date filed (Month, Day, Year)	32. Registrar's Signature	V.1	cour	······································	0 5-10/7		
	Registra		NCT 1 2 2011	March 17. STEEL	The same of the sa					

			For State Registrar	State of Marylar		artment of F tificate of D			ene 0 1 1	32615
ì	Physicia		1. Decedent's Name (First, Middle, Last) LIAM OPPIT	'Z	-		2. Date of Death	R ^D 6, 20 ¥°1	3. Time of Death 2:19 p M
	Medic Examin		4a. Facility Name (if not institution, give s	street and number)			Location of Death		4c. County of Death	
	Funeral		STELLA MARIS H 5. Social Security Number 6. Se		last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	9. Birtl	nplace (State or Foreign
	Director		044-58-6242 Usual Residence of Decedent	X ^{M 2 □ F} 85	Yrs.	Months Days	Hours Will.	AUG. 12	2,1925 M	IARYLAND
	yland f show ed at	tot	10a. State 10b. County		ty, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 X No
	he Mar or 28a- e notifi	Funeral Director	MD BALTI 10e. Street and Number	MORE	TIM	ONIUM 10f. Zip Code		10	g. Citizen of What Cou	
036	n with t	neral	2300 DULANEY V	ALLEY ROAD		210			U.S.A	۸.
	e filed within 72 hours after death with the Maryland ttal Hygiene. et other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates.		Vas Decedent of Hi f Yes, specify Cuba		ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: W	
15-0	72 hour "natu ledical	Completed	15. Decedent's Ed (Specify only highest grad		(Give	lent's Usual Occupa	ation during most of work	king 1	6b. Kind of Business/I	ndustry
212	within giene. er thar the M		Elementary/Secondary (0-12)	College (1-4 or 5+) 5 +	life. Di	O NOT use retired) PR	IEST		CATHOLIC	CHURCH
Maryland 21215-0036	Ild be filed within 7 Mental Hygiene. Iarked other than atic event, the Me	To Be	17. Father's Name (First, Middle, Last) JOSEPH OPPI	ጥ 2			18. Mother's Nan	ne (First, Middle, Ma FSA	aiden Sumame) RYJACEK	
any	1 and 2 should be in the factor of Health and Mente item 27 is marked other traumatic e		19a. Informant's Name/Relationship (Ty)				and Number or Rui	al Route Number, C	City or Town, State, Zip	
e,	and 2 s Health em 27 ther tra		REV. GERARD SZY			DULANE sition (Name of	Y VALLE		Oc. Location - City or	MD 21093
Baltimore,	Page nent c ant: If iry or		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	cemetery cren	natory or other plac	TERY 10		,	S, MARYLAND
Balt	permit. Departr Imports any inju		21. Signature of Fur Prince License		Ty Ty	TLLY & C	ŽÉILER ONKLING	INC. FU	NERAL HON, BALTIMON	ME 21224 RE,MD
ı			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only on	lications that caused the dea	-					Approximate Interval Between
	Ph _y sician Medical		Immediate Cause (Final disease or condition resulting in death)	a. PNEUMONTA Due to (or as a consec	uence of:					Onset and Death
	Examiner	<u></u>	Sequentially list conditions,	b						
	red	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Due to (or as a conseq	quence of):					
	icate be executed physician and is the burial-transit	al Exa	that initiated events resulting in death) Last C. Due to (or as a consequence of):							
760	cate be physic sthe b	ledical		d						
Box 68	ath certif attending for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No g ☐ Unknown	23c. If yes, outcome of pregn 1 Live Birth 2 Fet 4 Pregnant at time of 9 Unknown	tal death 3	Ectopic pregnanc Other (specify)	су		23d. Date of del Month	ivery Day Year
s, P.O.	requires that the der been signed by the s should be detached	ρ	Part II. Other significant conditions co	ntributing to death but not re	sulting in the u	nderlying cause giv	ven in Part I.	23e. Did toba	acco use contribute to	the cause of death?
Division of Vital Records,	The law requate has beer page 2 shou	Completed						24a. Was an autopsy perform 1 \square Yes 2	prior to death?	topsy findings available completion of cause of
Ita	ysician: The is certificate director, pag	Be	25. Was case referred to medical examiner? 1. ☐ Yes 2 🗶 No	Hospital:	7======================================	Oth	ace of Death (Chee		- V 0 (0	ify) HOSPICE
of V	ding Phys h. After this funeral d	ate: To	27. Manner of Death 1 Natural 5 Pending	1 Inpatient 2 28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injun work	y at :?	28d. Describe hov	nce 6 X Other (Spec. v injury occurred	ny) HOST ICE
ivision	il or Attending Pater death. Director: After din by the funer	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specif		M 1 ☐ Yes 2 ☐ No treet, factory, office 28f. Location (Street and Number of City or Town, State)				ral Route Number,
_	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in E	Medical	(Check 2 Medical Examin	ician: To the best of my know her: On the basis of examination e Practitioner: To the best of	on and/or inves	tigation, in my opinio	on, death occurred	at the time, date and	place, and due to the	cause(s) and manner stated
_	To the within To the compl	Σ	only one) 3 X Certifying Nurs 29b. Signature and title of certifier	e Practitioner: to the best of	my knowledge	29c. License			ed. Date signed (Month	
			30. Name and address of person who c	ompleted cause of death (Iter	m 23a) (Type, F	Print) /	7-11-12		10/6/0	<u> </u>
			JACKIE JONES, CI	חות החצים שות	ANEV VA	TIEV PD	TIMONI	JM, MD 21	093	
	Sta Registra		31. Date filed OCT 1 3 2011	32. Registrar's Sign	par	Co.				

DHMH 17 Rev 06-2011

ОСТОВЕК 6, 2011 2:19 р.ш.

JOSEPH OPPITZ

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Phillips 7:35 P M Yvonne October 2011 Medical Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Kandallotown - Northwest Hospice Baltimone leasons ttospice Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 6060 **Director** 1 □ M 2 🔀 F Irinidad 28 1931 or 28a-f show 10c. City, Town or Location 10d. Inside City Limits er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Pikesville Baltimore 1 Tyes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Painted USA 2120P permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event: the Medical Evantina man injury or other traumatic event. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Black If Yes, Give 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Security //Secondary (0-12) College (1-4 or 5+) + veavs Health Care Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mackenzie Cruck-shank 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 903 Painted Pikesville MD 2120B Phillips Fevgusor Koad Daughten 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other Burial 2 Cremation 3 Removal from State Pikesville, MD 2011 Druid Ridge Cerneten 15 10 Donation 5 Other (Specify) Vaughn C. Greene Funeral Services Signature of Funeral Service Licensee 22. Name and Address of Facility Koad Kandall Stown MD 21133 isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the shock or h eart fature. List only one cause on each line Interval Retween Onset and Death Event Immediate Cause Physician/ Cardiothrombotic disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Cardiovasiular Distase Atheroscierotic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury Hospital or Attending Physician: The law requires that the death certificate be executed ohysician and the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No 2 1 1 Yes Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 ☑ No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No Investigation Accident completely filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier NS Kay apamen. D 29d. Date signed (Month, Day, Year) 10/12/11 D0057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N: S Rajapakse, M.O. 2835 Smith Baltimore MD 2 1209 5 703 filed (Month, Day, Year) State OCT 1 3 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1 tem 5 per fh 9920 10-27-11 vt State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Ruth Hermann Pulaski 6:00 a October 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Mt. Airy Klein Hospice Center Social Security Number 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 M 2XXF Min. (Month, Day, Year, 26, 1 Months Days Hours Pennsylvania า๊925 86 Director 181 - 26Usual Residence of Decedent or 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland must be notified at Director 1 🗆 Yes 🏋 No Frederick MD <u>Frederick</u> 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ral", or items 23a Examiner must be Funeral U.S.A. 21701 2411 Bear Den Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 XX Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XXNo Specify: White "natural" 3-Widowed 4 ☐ Divorced Year or Dates. other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Veteran Affáirs Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Hospitals Head Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Sophie Franz George Hermann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12513 Kings Lake Drive, Reston, VA 20191 Karen Hermann - Niece 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lakemont
Memorial Gardens 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1
Department of
Important: If it
any injury or o Burial 2 Cremation 3 Removal from State onation 5 🗌 Other (Specify) Davidsonville, MD 10-15-2011 eral Se vice Licens All Name and Address of Facility Beall Funeral Home Signati NW Crain Hwy, Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury Due to lor as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the human-transit Exam attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Pregnant at time of death Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 Tes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an autopsy Yes nin 24 hours after death.

the Funeral Director: After this certific npleted filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) HOSDICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: Natural 28d. Describe how injury 5 Pending 1 Yes 2 No Accident Suicide Investigation Could not be 6 🗌 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature ar 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month ABRAHAM 1758 Medical PELBERG 2011 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SINAI HOSPITAL BALTIMORE **Funeral** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 PA 8. Date of Birth 1 🕅 M 2 🗆 F Days Min. Months Director 0271871927 159-32-2629 Yrs. 84 Usual Residence of Decedent 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a, State 10b. County Examiner must be notified at **Funeral Director** 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No MD N/A BALTIMORE 10e, Street and Number 10f. Zip Code 10a. Citizen of What Country? 3737 CLARKS LANE, #311 21215 USA 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. 3 Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ RABBI RELIGION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ MORRIS PELBERG ETHEL GOLDWAG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ESTHER PELBERG / WIFE 3737 CLARKS LANE, #311, BALTIMORE, MD 21215 20a. Method of Disposition
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of I Important: If ite any injury or ot 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) 10/12/2011 CHEVRA AHAVAS CHESED RANDALLSTOWN, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., Mats 8900 REISTERSTOWN ROAD, PIKESVILLE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) a. ISCHEMIC CARDIOMYOPATH Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial Physician/Medical that the death certificate be use as t attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year the g Unknown Unknown signed by t 1 be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires Completed 1 ☐ Yes 2 🕱 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has performed 1 🗌 Yes 2 🗌 No Yes 2 X No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 🔀 No ပ Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work?
1 Yes 2 No 24 hours after death Funeral Director; A Accident Investigation Could not be Suicide

Division of Vital Records, P.O. Box 68760

State Registrar

DHMH 17 Rev 7/2009

filled in by

соmpleted

within 2 To the I

Medical

3 ☐ Suicide 4 ☐ Homicide

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

29a. Certifier

GIZAW

determined

RGITHW H. WULDEHINOT

WOLDEHINOT.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

2434

1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D0063327

W- BELVEDERE, AVE, BALTIMORE, M.D.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

29d. Date signed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Corrine Scott Rooks 10 07 2011 Medical 8:00a 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Cranberry Cottage II Glen Burnie Anne Arundel Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2√ F Days Hours Min Director Yrs <u>098-</u>30-6304 88 30 MD Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Anne Arundel Glen Burnie 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 111 North Hollins Ferry Road 21061 U.S.A. 12. Was Decedent Ever in U.S Was Deceue...
Armed Forces?
1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. Specify: Black ¾☐ Widowed 4 ☐ Divorced Completed ed other than "nature event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) if Health and Mental Hygiene. item 27 is marked other tha other traumatic event, the M <u>12th grade</u> 4yrs Registered Nurse Public Health Dept Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Richard Perry B. Scott Cora Hammond 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21061 Paula F. Rooks-Daughter 105 North Hollins Ferry Road, Glen Burnie 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of I-Important: If ite any injury or ot 20c. Location - City or Town, State 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 4 ☐ Ponation 5 ☐ Other (Specify) cemetery, crematory or other place) On-Site 10/13/2011 Baltimore, Md eral Service Licensee 21. Signa 22. Name and Address of Facility March F/H West 4300 Wabash Av Wabash Ave, Baltimore, 21215 23a. Part Part I. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betw Interval Between Onset and Death Immediate Cause (Final Ph sician/ men disease or condition resulting in death) 891 Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Examir physician and s the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 use as t attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No ģ 5 Other (specify) Pregnant at time of death Month Day Yes the detached a Unknown P.O. | þ s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l autopsy certificate 1 ☐ Yes 2 ☐ No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to —dical examiner? Be 26. Place of Death (Check only one) Other: 1 Yes - 2 No ပ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Mann of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 2 Accident 1 Tes 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 🖵 🗲 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🖂 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of of title 29c. License number 29d. Date signed (Month, Day, Year) 10 0. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 32620 2011 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day Y September 15, 2011 2110 hrs **Medical Examiner** Theron Rollins Jr 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Allegany Cumberland 10900 Mason Road If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number un 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Months Davs Director CountryWirginia Jan 4, 1945 1 X M 2 F 66 Yrs Usual Residence of Decedent 10d. Inside City Limits 103 10a, State 10b. County 10c. City, Town or Location 1 Yes 2 No 28a-f shov Allegany Cumberland death with the Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 USA 16 Queen City Drive 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married 2 X No __ Yes 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: white permit. Pages 1 and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examinor Š 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) leted during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 financial 12 loan officer Som 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lucille Bennett Theron Rollins Sr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1782 Sherry Lane Jonesboro, GA Paul Rollins/brother 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: in state 21. Signature of Eureral Service Licentary and e ²²State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 23a. Parly. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line Medical Death a Subdural hematoma Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical AMENDED 23a, pt. II, 27, 28a-f, per me, g920 10-21-11 sm attending physician a or use as the burial -X UNPENDED The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Month Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ě 1 Yes 2 No 3 Probably 4 V Unknown Cirrhosis of the liver, chronic alcohol use Completed 24a. Was an 24b. Were autopsy findings available certificate has been prior to completion of cause of autopsy death? performed' ✓ Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Hospital or Attending Physician: Be examiner? Other Nursing Home 5 Residence 6 Other: Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA this 1 Yes 2 No 28a. Date of Injury (Month, Day, Yea 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 27. Manner of Death probable head injury Natural 1 Yes 2 X No Pending Director: fd 9-15-11 fd 9:00 pm 24 hours after death Funeral Director: 2 X Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) $10900\ Mason\ Rd$. Cumberland, Md . 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide mote1 determined (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. S 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier September 16, 2011 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Donna M. Vincenti, MD 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Moath Day, kegistrar's Signatu rack

DHMH 17 Rev 1/2001 **OCME 2006**

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 20 | 3262 | State of Maryland / Department of Health and Mental Hydiene

yrone Slowe		1-For State Certificate of Death		
Physici	an/	Registrar	Reg. No. 2. Date of Death	3. Time of Death
Medical Exami			Month Day October 9, 2011	Year 0957 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Good Samaritan Hospital Baltimore	h 4c. Cour	nty of Death
		Good Samaritan Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs	s 8 Date of Birth (MM/DD/X)	YYY) 9. Birthplace (State or
Funeral Director		Months Days Hours Mir		Foreign Country)
		Usual Residence of Decedent	112-21-1951	13/3
'any		10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
uyland Sa-f show et once.	JO.	MD Battimore		1 Yes 2 No
Mary r 28a-	Director	10e. Street and Number		What Country?
death with the Maryland or items 23a nr 28a-f sho must be notified at once				ace - American Indian, Black,
eath w items	Funeral	1 Never Married 2 Married 2 Married 1 Yes 2 No		/hite, etc.
	by Fu		Specia	ity: Black
hours a				f Business/Industry
36 hin 72 l e. than "l edical I	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+)	F007	Industry
5-0036 lled within 7 Hygiene. I other than	Com	17. Father's Name (First, Middle, Last) 18.Mother's Name	e (First, Middle, Maiden Surna	
215 be file ntal Hi	Be (Calvin Slowe Sara	h Moore	/
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a nr 28a-f she matic event, the Medical Examiner must be notified at once	ဥ			
ore, MD 21215-003 s I and 2 should be filed within of Health and Mental Hygiene. If item 27 is marked other the traumatic event, the Med		Keisha Mosby Dungber 2583 Edmondson 20a. Method of Disposition (Name of cemetery,		<u>to⋅MD</u> 21223 on - City or Town, State
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours afte Department of Health and Mertal Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examines		1 Burial 2 Cremation 3 Removal from State crematory or other place)	11.	3.17
it. Pa artmen ortan		4 Donation 5 Other Specify: 1700 Ce Me tary 101 21. Signature of Funeral Service Licensee 22. Name and Address of Excility 1	17/201/30	Himore M
Balti permit. Departor Imports injury n		3nu of 3fre mo1636 4905 your Red	Balko MI	D21212_
Physician		23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac of failure. List only one cause on each line.	or respiratory arrest, shock, or	heart Approximate Interval Between Onset and
~ √ /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Atherosclerotic Cardiov Due to (or as a consequence of):	ascular Disea	se Death
		b		
	ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause		
	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		
ecuted and transi				
60, ate be ex hysician e burial -	Physician/Medical	☐ AMENDED 23a,27,per me,g921 11-21-11 sm		
876 tificate ng phy ss the l	M/L	IF FEMALE: 23b. Was decedent pregnant in the part 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy		e of delivery h Day Year
Box 6876 The death certificate The attending phened for use as the	sicia	past 12 months? 4 Pregnant at time of death 5 Other (Specify)		
D. Be to the des	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use co	ontribute to the cause of death?
P.C es that	2		1 Yes 2 No	3 Probably 4 Unknown
of Vital Records, ig Physician: The law required the this certificate has been sineral director, page 2 should the	Completed		24a. Was an 24 autopsy	b. Were autopsy findings available prior to completion of cause of
Reco The law cate has	E C		performed? 1 ✓ Yes 2 No	death? 1 ✓ Yes 2 No
tal Rection: The certificate ector, page	BeC	25. Was case referred to medical 26.Place of Death (Check		
Vita bysici this c	10 B	1 V Yes 2 No	ng Home 5 Residence	
n of ding Pl		(Month, Day, Year)	28d. Describe how injury occ	curred
Division tal nr Attendi rs after death.	cati	2 Accident Investigation 28e Place of Injury - At home farm street, factory, office building, etc.	28f. Location (Street and Nu	imber or Rural Route Number, City
Div pital or ours afte ceral Dii	Certification:	3 Suicide 6 Could not be determined (Specify)	or Town, State)	
Hosp 24 hou Function		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and	d due to the cause(s) and man	nner as stated.
Di To the Hospital within 24 hours a To the Funeral I completely filled	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.		
	Σ	29b. Signature and title of certifier 29c. License number O.C.M.E.	150	igned (Month, Day, Year) 10, 2011
	ļ	30. Name and address of person who completed cause of death (Item 28a)		
(P)		Theodore M. King, Jr., MD. Assistant Medical Examiner 900 W. Baltimore Street, B	Baltimore, MD 21223	
	-		-7	
Reaist				

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ 201 Medical Town, or Location of Death 4c. County of Death **Examiner** 9. Birthplace (State or Foreign . Age (In vrs. last birthday) Date of Birth (Month, Day, **Funeral** Month Min. Director 6 28a-f show 10b. County 10c. City, Town or Location the Maryland notified at Director 1 Yes 2 No Bivalve Maryland Wicomico 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ö ms 23a or must be n Funeral USA 21814 4066 Water Front Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Examiner Armed Forces? Black, White, etc. ò þ 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 XNo Specify: White "natural" 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Secretary 12 Medical other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o Department of Health and Menta Important: If item 27 is marked any injury or other traumatic once. မ Beck Mary Musacchio Frederick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4066 Water Front Rd, Bivalve, Md . 21814 William Schott, Jr. / husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 🗆 Cremation 3 🗀 Removal from State Anatomy Board of Maryland | 10/9/2011 Baltimore, Md. 21201 4 Donation 5 Other (Specify) Signature 22. Name and Address of Facility 1050 York Rd. Ruck Towson Funeral Home, Inc. Towson, Md. 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cancer disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) burial-transit Cause (Disease or injury that initiated events resulting in death) Last nding physician and use as the burial-tran Due to (or as a consequence of) Physician/Medical Box 68760 use as yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy page 2 this certificate **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred hin 24 hours after death.

the Funeral Director: After in pletely filled in by the funer 1 ANatural 5 Pending work? 2 🗌 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. within To the 29b. Signature and title of certifie License numbe Oct. 10, 2011 D0039

Registrar
DHMH 17 Rev 06-2011

State

Bennett W.
31. Date filed (Month, Day, Year)

3 2011

Carroll

deress of person who completed cause of death (Item 23a) (Type, Print)

100

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Octobe 2011 Baby Girl Soby Twin B /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Johns Hopkins Bayview Medical Center **Baltimore** Birthplace (State or Foreign
Country) 5. Social Security Number 6. Sex If Under 1 Year_ If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 M 2 X F Director 12 19 Sept 30, 2011 Maryland infant Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County show at 1 ☐ Yes 2√ No or 28a-f sh notified a Director Waldorf MD Charles 10e. Street and Number 10f. Zip-Code 10g, Citizen of What Country? 23a or must be USA 20601 2778 Pinewood Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, 11. Marital Status Black White etc. Examiner 1 Yes 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 ò white 1 ☐ Yes 2 💢 No Specify: þ 3 Widowed 4 Divorced Year or Dates: natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) the Medical College (1-4 or 5+) Elementary/Secondary (0-12) and Mental Hygiene. infant infant infant traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carla M. Ferguson Clayton John Soby ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4940 Eastern Avenue Baltimore, MD Johns Hopkins Bayview Med Ctr item 27 i 20c. Location - City or Town, State 20a Method of Disposition 20b. Place of Disposition (Name of Date Department of H Important: If ite any injury or ot once. cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 ☑ Other (Specify) in state 21. Signature of Funeral Service License Ronal d S 23 Name and Address of Facility Board 655 W. Baltimore Street 21201 Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final **Physician** Due to (or as a consequence of) hours disease or condition resulting in death) /Medical Examiner xtreme Sequentially list conditions, Examiner if any, leading to inimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed nding physician and use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal dea 2 Fetal death Ectopic pregnancy ξ in the past 12 months? Month Day Year 5 Other (specify) 2 X No ate has been signed by the a page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 2 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? I or Attending Physician: The lav after death.
Director: After this certificate has director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA ၉ filled in by the funeral 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of 28c. Injury at Work? Certification: 1 Natural (Month, Day 5 Pending investigation 2 🗌 No 1 Yes 2 Accident 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Could not be Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) To the within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie

State Registrar

DHMH 17 Rev 1/2001

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Uctober

4940 Eastern Avenue, Baltimore, MD, 21224

2011

DHMH 17 Rev 1/2001 OCME 2006

Registrar

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month C+ Physician/ Giuseppe SANO 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ARKVILLE OAK Crest ILLAGE If Under 1 Year | If Under 24 Hrs. 8, Date of Birth Months | Days | Hours | Min. | (Month, Day | 1/-24 9. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) Funeral 1**X** M 2 □ F 90 214-30-607 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director ARKVILLE 1 Tes 2 No MARYIAND 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 8830 21234 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married 21215-0036 Specify: White 1 Yes 2 No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) BANNER Be Maryland 18. Mother's Name (First, Middle, Maiden Surname, 17, Father's Name (First, Middle, Last) ၉ enede HNYONINA 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other tran YOINCH IRCLE-Unit D BRUSH - DANGHTER WILLRICH MDZIOSO 311 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Oct 14, 2011 4 ☐ Donation 5 ☐ Other (Specify) ZMNINO JR. FIH Joseph 21. Signature of Poneral Service Licensee 22. Name and Address of Facility 2 5% Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disea Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to Immediate cause. Enter onderlying Cause (Disease or linjury Due to (or as a consequence of) Exami attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 1 Yes 2 L 9 Unknown been signed by the a should be detached t g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy perforn Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate completed filled in by the funeral director, pag 1 🗌 Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) SAND Division of Vital Be examiner? Hospital 2 No 1 Tes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 \(\text{Yes} injury 5 Pending 2 🗌 No Accident Suicide Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29d. Date signed (Month, Day, Year) RO67343 10-12-2011 BIRD Parkville, MD. 21234 MBRAZIOR State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 32626 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death OCTOBERDay 2, 2011 Physician/ ALLEN STAMATELOS SR. 5:30 a M RICHARD Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE N/A 505 S. BOND STREET If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 **X** M 2 □ F Months Days Hours MAY 9, Yar 9 40 71 PENNSYLVANIA 216-36-3787 Yrs **Director** Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1X Yes 2 No MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 505 S. BOND STREET 21231 U.S.A. within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. by 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🕅 No Specify: ed other than "natural", event, the Medical Exa Specify: 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) PAINTER CONSTRUCTION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 JOHN STAMATELOS N/A SADIE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PATRICIA STAMATELOS/WIFE BOND STREET, BALTIMORE, MD. 21231 505 S. altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 XI Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) SACRED HEART OF JESUS 10/15/11 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) ZILLY & ZEILER INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTIMORE, MD 21231 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph_{sician/} vascular cardin mereusive disease or condition Medical resulting in death) Dual of or as a consequence of): Examiner Sequentially list conditions, Due to for as a consequence of cause. Enter Underlying Cause (Disease or linjury that initiated events and -transit Exami Due to (or as a consequence of): resulting in death) Last burialattending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Day Year Pregnant at time of death the 9 Unknown P.0. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed eral Director: After this certificate filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No Yes 2 N 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 🗌 No မ ER/Outpatient 3 DOA 1 🗌 Inpatient 2 🗌 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No after death Accident
Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier npleted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 20/2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar mo

Registrar's Signature

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31. Date filed (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygien Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician AM 5:28 OMPSON Clarence 10 1106 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex **Funeral** 1**X**OXM 2 □ F Months Days Hours Min. 213-62-0320 55 2-31-55 FL. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b County X⊓Yes 2 No or 28a-f s notified MD NA Baltimore Director 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? ö items 23a or ner must be n 21231 USA 224 N. Chester Street Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. African Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 No Specify þ Specify: American 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify onfy highest grade completed) ntal Hygiene. ed other than " event, the Med College (1-4 or 5+) Elementary/Secondary (0-12) Maaco Auto & Repair Painter 12th Grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be th and Mental F 27 Is marked of traumatic even Bernice Lawton William Thompson, Sr. 9 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a Diane R. Thompson-Wife 224 N. Chester Street Baltimore, MD. 21231 permit. Pages 1 and Department of Health Important; if Item 27 any injury or other troonce. 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 20a. Method of Disposition 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State Woodlawn Cem. 10-17-11 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wylie Funeral Home P.A. 21. Signature of Funeral Service Licensee 638 N. Gilmor Street Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final tailure Kespiratory Physician HOURS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician; The law requires that the death certificate be executed g physician and as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) d by the al 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Was autopsy performed 2 No certificate has b 2 🗹 No 1 Tyes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 No 1 Inpatient 1 Tes 2 ER/Outpatient 3 DOA 0 After this funeral c this 28a. Date of Injury (Month, Day Year) 27. Manyer of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural Injury 1 Yes 2 🗌 No within 24 hours at er death.

To the Funeral D rector At completely filled by the fi 2 Accident Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie RES-000 October 10, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Avenue, Baltimore, MD, 21224 Kornberg lichael

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 4 Day 2011 Year Cesar C. Tan 11:31 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery General Hospital Montgomery 01ney If Under 1 Year If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday 8. Date of Birth **Funeral** Days Min (Month, Day, Year) 649-16-8539 **Director** 1 🛛 M 2 🗆 F 63 June 15, 1948 Philippines Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6900 Barrett Lane 20814 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🖺 No Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify. Asian "natural", Specify: Completed 3 - Widowed 4 - Divorced Year or Dates or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. Personal Assistant Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Tan Lian Kim Maria Cansino 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Modesta Tan/Wife 6900 Barrett Lane, Bethesda, Maryland 20814 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State October 13 Montgoinery 1 Burial 2 X Cremation 3 Removal from State Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2011 Crematorium, Bethesda-Chevy 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/ Chase, Inc. 7557 Wisconsin Ave., Bethesda, Maryland 20814-3501 M00198 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ 4 145 Uas disease or condition Medical resulting in death) **Examiner** 8 HOURS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examin physician and sthe burial-trans resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 nding p IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ò in the past 12 months? Month Pregnant at time of death 2 No 9 Unknown g Unknown been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use coptribute to the cause of death? by MELCITUS 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2: autopsy 2 🗌 No Yes 2 No 1 Yes 25. Was case referred to medical examiner? completely filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital Other: 2 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending after death. 1 Yes 2 No Accident М Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) OB. Hara

Registrar
DHMH 17 Rev 06-2011

State

18111 BRINCE PHILLIP DR #300 OCNEY MD 2083 2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

egistrar's Signatur

HARDING M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Physician 201 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner 0. 8. Date of Birth (Month, Day, Nov. + Age (In yrs. last birthday Birthplace (State or Foreign
 Country) **Funeral** Year) Months Days Hours Director 10c. City death with the Maryland 10a. State Town or Location 10b. County show 1 No es 2 No ns 23a or 28a-f sh must be notified Funeral Director Altimor 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code TVE NUE Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 'natural", or Items Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 12. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 100 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Completed by 3 Widowed 4 Divorced Item 27 Is marked other than "nature other traumatic event, the Medical 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Majden Surname, To Be and Mental 19a. Informant's Name/Relationship 19b. Mailing Address (Street and Number or Rural Poute Number, City or Town, State, Zip Code) ma 21229 STORIA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition ₽ 1 Burial 2 □ Cremation 3 ☐Removal from Sta ō Important: If any Injury or 5 Other (Specify) 4 Donation 21. Signatu 21213 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each fire the death. Do not enter the years Immediate Cause (Final Physician Atheroscheroti disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner The law requires that the death certificate be executed burial-transi resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician the attending p IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 9□Unknown 5 Other (specify) signed by the a 1 ☐ Yes 2 No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 200 No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an page 2 autopsy perform certificate To the Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To After this s after death.
Il Director: After this d in by the funeral d 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I

completely filled 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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31. Date filed (Month, Day,

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Irvin Wallace 2011 09-30 3:23p Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death 4b. City, Town, or Location of Death Prince Georges Hospital Cheverly Social Security Number **Funeral** If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Hours (Month, Day, 09-23) Country) WashingtonD(Director 219-76-0464 53 Usual Residence of Decedent show 10a, State 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Director 28a-f 1 X Yes 2 No MD PG Cheverly 10e. Street and Number ö 10g. Citizen of What Country? Funeral 23a 6695 Old Landover Road 20785 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian the Medical Examiner 0 Black, White, etc. 2 1 Never Married 2 Married 1 Yes If Yes, Given 2 X No 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", Completed 3 Widowed 4 Divorced Year or Dates Black 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne any injury or other traumatic event" 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 3yrs Disabled None Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Robert Wallace India Samuels 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deirdre M Wallace (wife) 6695 Old Landover Rd, Cheverly MD 20785 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town. State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Mem. Cem 10-11-11 Suitland, Maryland Signature of Funeral Service Licensee Robert G. Mason Funeral Home 1661 Good Hope Rd. Wash. 23a. Part 1. Ent. the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Approximate Interval Between FATAL CARDIAC Immediate Cause (Final Physician/ Onset and Death ARRHYTHMIA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner STAGE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events.) quantially list conditions, Examine Due to (or as a consequence of sicia and burial-trans resulting in death) Last Due to (or as a consequence of): Physician/Medical certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) Month Day Year Pregnant at time of death 1 | Yes 2 | 9 | Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by or Attending Physician: The law requires Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1 🗌 Yes 2 🗆 No Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 Oo Division of Vital director, Be 26. Place of Death (Check only one) Other: ည 1 Inpatient 2 ER/Outpatient 3 IDOA 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 1 ☐ Yes 2 ☐ No after death Director: completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, Death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certiffing Myrse Practioner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) within To the 29b. Signature and title of 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL DR. CHEVERL

Registrar DHMH 17 Rev 7/2009

State

SATTARIAN

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1050 AM SOC nae Medical Octo bero 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death N/A 4b. City, Town, or Location of Death It more last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Month, Day, Year)
11ne 7,1946 1 🛣 M 2 🗆 F Months Hours Min 218-42-4825 Director Pennsylvania June Usual Residence of Decedent show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No MD Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1701 Drexel Road 21222 United States within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2X Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: Completed 3 Widowed 4 Divorced White Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainmatic. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Years Millwright Steel Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Paul Wilson , Jr. Marie Winkleman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Verna Mae Wilson (Wife) 1701 Drexel Road Dundalk, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Holy Rosary Cemetery | 10/10/2011 Baltimore, Maryland 21. Signature of Funeral / e lice Licens 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk. Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Pulmonary Embolis disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Vein Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to r as a consequence of the burial-transit Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria by Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been sinned by the attending the control of the Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No 1 Yes 2 Unknown Month signed by the a d be detached f by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To Be Completed 1 Yes 2 No 3 Probably 4 Unknown plnous 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) examiner? Hospital: 2 🗌 No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Director: After Natural 5 Pending injury 1 Yes 2 No Accident Investigation M 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Sertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 131208 october 07,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 N Wolfestoret MO 21282 31. Date filed (Month, Day, Year) . Registrar's Sign State

Registrar

13

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 32632 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 11, 2011 Arlene В. Walsh 8:15 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gaithersburg Montgomery Wilson Health Care Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Pennsylvania Hours January 18, 162-24-8802 82 Director Usual Residence of Decedent items 23a or 28a-f show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Gaithersburg 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 211 Russell Avenue 20877 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Was Decedent Ever in U.S. Race - American Indian. Armed Forces? Black, White, etc. 1 \square Never Married 2 \square Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates White 3 X Widowed 4 Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Primary School Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Robert R. Blank Ruby Smurthwaite 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7701 Woodmont Avenue, Apt. 1107, Bethesda, MD 20814 Jeffrey D. Walsh /Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) October 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Montgomery Crematorium, Inc Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2011 Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 First the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock for heart failure. List only one cause on each line. nset and Death Immediate Cause (Final Physician/ Advanced breast careinoma disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate Examine Due to lor as a conse uence of cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial-transi Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed Hospital or Attending Physician: The I 24 hours after death. Funeral Director: After this certificate h 1 Yes 2 No **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate; 28c. Injury at (Month, Day, Year) 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death paccurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 04115 1 Hobert Derschle 30. Name and address of person who completed cause of death (Item \$3a) (Type, Print) · RUBERT & IRSCI18AC

OHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32/Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 5, per inf, g920 10-28-11 sm State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ $\underline{201}^{\text{Year}}$ Betty Jean West October 10, 12:40 AM Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Hospice Casey House Rockville Montgomery Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth
(Month, Day, Yea
October 23, **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 🗆 M 2 🕱 F Months Days Hours Director 85 Pennsylvania Usual Residence of Decedent show 10a. State 10b. County notified at 10c. City, Town or Location Director 10d. Inside City Limits 28a-f 1 💢 Yes 2 □ No Maryland | Montgomery Rockville ö 10e Street and Number 10f. Zip Code must be 10g. Citizen of What Country? 23a Funeral 9305 B Wescott Place 20850 United States Page 1 and 2 should be filed within 72 hours after death wment of Health and Mental Hygiene.
sant: If item 27 is marked other than "natural", or items; ury or other traumatic event, the Medical Examiner mus 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 2 X No 1 ☐ Yes 2 X No Specify Completed 3 X Widowed 4 ☐ Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev ပ Thomas Frederick Leppanen Aina Kulmala 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brian G. West/Son Barts Circle, Lutherville, Maryland 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State October 14, 4 ☐ Donation 5 ☐ Other (Specify) Crematorium, Bethesda, Maryland 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home, Rockville, Inc. B00 W. Montgomery Ave., Rockville, Maryland 20850 Haran hails M01530 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph. sician/ disease or condition Liver Neoplasm Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examiner Directo for sella consequence of y cause. Enter Underlying Cause (Disease or iinjury that initiated events and burial-trar resulting in death) Last Due to (or as a consequence of): physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? ned for Day Pregnant at time of death Month Year Yes 2 XNo 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diabetes Type I 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 😾 Unknown page 2 should Systematic Lupus 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 X No death' 1 Yes 2 No ours after death.

eral Director: After this certific filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: $_{4}$ \square Nursing Home $_{5}$ \square Residence $_{6}$ X Other (Specify) Hospice1 Yes 2 X No 욘 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 2 Accident X Natural 5 Pending Investigation M 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined Hospital within 24 hours a Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed : (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) and title of certifier 29c. License number SIE D27142 October 10, 2011. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Geoffrey Coleman, 6001 Muncaster Mill Road, Rockville, Maryland 20855 M.D.

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

OCT 1 3 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 32635 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Raymond Walls ΔM^M Medical September 201 .20 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Manor Care Rossville Rosedale Baltimore 5. Social Security Number 8. Date of Birth
(Month, Day, Year)
Dec 14, 1918 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 9. Birthplace (State or Foreign Days 1 X M 2 - F Months Hours Min. West Virginia 235-16-5632 Director 92 Dec Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a, State within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits MD 1 Yes 2 No Baltimore Rosedale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 600 Ridge Road 21237 USA items ; Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Examiner 14. Race - American Indian, Armed Forces?
1 ▼ Yes 2 □ No 10, Black, White, etc. 1 Never Married 2 Married 1 X Yes 2 No If Yes, Give Year or Dates. WWII ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Completed 3X Widowed 4 □ Divorced white Specify. marked other than "natu matic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha quality inspector Bethlehem Steel permit. Page 1 and 2 should be filed of Department of Health and Mental Hyg Important; If item 27 is marked othnany injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeffrey Walls/son 2392 Paddington Court Waldorf, MD 20602 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) 25 tarted Address of The Board 655 W. Baltimore Street peral Service rector 21201 Baltimore, MD Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, on heart failure. List only one cause on each line. Interval Between Immediate Cause (Final ASCND Onset and Death Filysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Year the 9 Unknown Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been irector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 25. Was case referred to predical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA this Nursing Home 5 Residence 6 Other (Specify, 27. an of Death Director: After the in by the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar (Check

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mittal

Waltham

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practionar: To the basis of my knowledge doubt contained at the time. Sets on place, the course(s) and manner as stated.

D0069314

29d. Date signed (Month, Day, Year)

Partitle Mp

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death VV 00D Physician OBER 07 Year 2011 EDWARD 05:42 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE. HARBOR HOSPITAL 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months Days Min Yrs Director KENTUCKY 219-18-9466 87 4-24-1924 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examination at 1 X Yes 2 No Funeral Directo MD. N/ABALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 301 McMECHEAN ST 21217 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Pyes 2 □ No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after of ment of Health and Mental Hygiene. In and 1 filem 27 is marked other than "natural", or itel any or other traumatic event, the Mcdical Evan in the Market of the Market brain in the Market bra Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 □ Yes 2 No þ Specify: BLACK 3 → Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) BUSINESS OWNER PUBLIC RELATIONS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be FRANCIS WOOD NELLIE HUGHES ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JAMES E. WOOD JR(SON) 1104 BRYN MAWR RD. BALTIMORE, MARYLAND 21210 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 5 Pother (Specify)ENTOMBMENT GARRISON FOREST VETERANS 4 Donation DWINGS MILLS, MARYLAND al Service kicensee ONATHAN D. HIBNER 2. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shocl, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat / ause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a 1 □ Yes 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown spital or Attending Physician: The law requir ours after death. eral Director: After this certificate has been si filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No 2 □ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ☑ Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital of within 24 hours a To the Funeral D 29a. Certifier Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Μ. CTOBER 07, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Or. HASSAN MASRE 3001 S HANOVER STREET, BALTEMORE, 21225, MARYLAND.

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

32. Registrar's Signature

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Marie Young		1- For State	Sta	ate of Maryla		ertificate of		and	Menta	al Hy		Dan Na	20		326	37
Physic			• •	,Last)						2	. Date of De		Voor		3. Time of Death	
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		5625 Frank	ford Avenue	· •	nber)		4b. City, Too Baltimo		ocation of	Death		40	c. County of	Death		
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	1	Usual Residence o		201		113	•]				sept	24,	1923		""Maiyi	and
w any		10a. State	10b. County		10c. City	y, Town or Locat	ion							- 1	10d. Inside City L	
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more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Montal Hygiens, and the Health and Montal Hygiens, and use if I item 27 is marked other than "natural", or items 22a or 28a-f shown other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status	rankior	d Avenue		16 142 14/6	- Page 45-4	212		0.4.0			USA			
eath w	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Ric					city Yes or N can, etc.)	0-	14. Race - / White, e		an Indian, Black,					
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Baltimore, permit. Pages I ar Department of He important: If ite		20a. Method of Disp 1 Burial 2		3 Removal from		Place of Disposi crematory or oth		of ceme	tery,		Date	20c. I	Location - Ci	ty or T	own, State	
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Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier 1 Cone) 2 V	ertifying Phys ledical Examir	sician: To the best of ner:On the basis of e	xamination ar	ge, death occurre nd/or investigatio	ed at the tim on, in my opi	e, date a inion, de	and place, ath occurr	and due	e to the caus e time, date	se(s) and and place	I manner as ce, and due t	stated. to the o	ause(s)	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygie Pen 32638 1 - For State Ragistrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** SEP 24, Velma 2011 Vernadene Alexander 0230 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2845 Blue Spruce Silver Spring Montgomery If Under 1 Year If Under 24 Hrs.

Wonths Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 X F Director 555-30-1925 85 OCT 08, Usual Residence of Decedent with the Maryland r 28a-f show 10a State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No MD Montgomery Silver Spring Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code "natural", or Itams 23a or 25 Tivoli Lake Court 20906 United States death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. nent of Health and Mental Hygiene. ant: If item 27 is marked other then "natural", or Itar 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Caucasian 3 XWidowed 4 ☐ Divorced Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Salesperson J.C. Penney - Retail 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Vernon Leslie Shore ၉ Minnie Armeita 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carl Vernon Alexander / Son 25 Tivoli Lake Court, Silver Spring, MD 20906 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State ö 1 X Burial 2 □ Cremation 3 X Removal from State Riverside Mem. Park permit. Page Department of Important: If any injury or once. ' 4 ☐ Donation 5 ☐ Other (Specify) 10/03/2011 | Tequesta, FL 21. Signature of Funeral Services icensee 22. Name and Address of Facility
Thibadeau Mortuary Service, p.a. Men M00956 7 Park Avenue, Gaithersburg, MD 20877 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) CIRRHOSIS 10 YEARS /Medical Due to (or as a consequence of): Examiner CHRONIC HEPATITIS C 10 YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial at an certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physiclan/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 1 ☐ Yes 2 🗓 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CHRONIC ATRIAL FIBRILLATION 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an CONGESTIVE HEART FAILURE autopsy performed? 1 Yes 2 X No 1 Yes 2X No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Group Other: 4 Nursing Home 5 Residence 6X Other (Specify) 1 ☐ Yes 2 🔀 No 2 2 ER/Outpatient 1 Inpatient 3 DOA Home 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Injury at Work? After 1 X Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 3 🗀 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) illed in by determined 4 Homicide hours after within 24 hours a To the Funeral C 1X Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number armen mo D24543 September 26, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James A. Rossi, M.D., 3305 N. Leisure World Blvd. Silver Spring, MD 20906 31. Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 28 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 26,2011 Physician/ Chizuko Bernstein September 8:09 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hebrew Home of Greater Washington Rockville Montgomery If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number **Funeral** 8. Date of Birth Days Hours (Month, Day, 1 □ M 2 😿 F **Director** Japan 553-60-9775 80 January , 1931 Usual Residence of Decedent ıral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Montgomery Takoma Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 406 Belford Place 20912 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: "natural", 3 🗆 Widowed 4 🛣 Divorced Specify: Asian Year or Dates any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Housewife Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ unknown unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Bernstein, son 406 Belford Place, Takoma Park, Maryland 20912 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Fort Lincoln Crematory 9/30/2011 Brentwood, Maryland 21. Signature of Funeral Service Licensee MO1102 22. Name and Address of Facility Simple Tribute 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Cancer iver disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Hepatitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that introduce are or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗌 No 1 🗌 Yes Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 X Nursing Home 5 A Residence 6 Other (Specify) <u>မ</u> 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 Yes 2 🗌 No

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and Box 68760 P.0. Records, Division of Vital completed filled in by the funeral director,

Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) mira farli, MD 9-26-11 D0064871 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rockville MD 20852 Montrose 6/21 Fazli MD 31. Date filed (Month, Day, Year) 82. Registrar's Signature

Registrar DHMH 17 Rev 7/2009

State

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month 1127 AM exto madwai 2011 ICE Medical 4a. Facility Name (if not institution, give street and number) 4b. City Town or Location of Death Examiner 4c. County of Death NMSof Hagerstown Washington Hagerstown Social Security Number Date of bit... (Month, Day, If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birtholage (State or Foreign **Funeral** Months Min 1 □ M 2 🛛 Pennsylvania 89 **Director** 215-18-2430 ์วีจี2 : Dec. Usual Residence of Decedent shov 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 Yes 2 X No Washington Maryland Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? be Funeral 23a must 16719 Mount Williams Circle 21795 USA death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner 5 þ 1 Never Married 2 Married Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No Specify: "natural", Specify: White Completed 3 X Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) nt of Health and Mental Hygiene.

If item 27 is marked other than
or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Her own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental H ျ William Keifer Hull, Sr. Beatrice Viola Schrack 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Kenneth E. Eckstine, Jr. - Son 16713 Mount Williams Circle, Williamsport, Md.21795 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot Date 1 → Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) cemetery, crematory or other place, Hill Cemetery 9/30/2011 Hagerstown, Maryland 21. Signatur uneral Service Lip 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition oronari Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): -transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Year Pregnant at time of death Yes 2 No 9 Unknown g Unknown P.O. signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an nas autopsy performed? Yes 2 N page certificate 2 🗌 No Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 🗌 Yes 2 No ၉ 1 Inpatient 2 I ER/Outpatient 3 I DOA After this 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred or Attending 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation 24 hours after death Funeral Director: Suicide 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 3 XCertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier ADAMIE! ess of person who com eleted cause of death (Item 23a) (Type, Print) 14014 Marsh Pike Hagerstown

State Registrar phanic

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar 3264 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 23 2011 Thomas Alvin Burns, Jr 2:26 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1092 Kasinof Ave. Washington County Hagerstown 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Dec. 26,1924 257-24-5166 Georgia **Director** 1 🗓 M 2 🗆 F 86 ms 23a or 28a-f show must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington County 1 ☐ Yes 2X No Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral permit. Page 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other there any injury or other traumair. 1092 Kasinof Ave. 21742 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Was Decedent Ever III 0.5.

Armed Forces?

1 X Yes 2 No

If Yes, Give 1943

Year or Dates. 1946 Black, White, etc. by 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify. White 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Information Technology Financial Analyst 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Thomas A. Burns, Sr. Ethel Freeman Burns 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathryn Anne Stonestreet-daughter 13303 Glendale Dr. Hagerstown, MD 21742 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Smithsburg Crematory 9-26-2011 Smithsburg, MD 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21 Signature of Funeral Service Licensee 1331 Eastern Blvd. North Hagerstown MD 21742 23a. Part 1. Enter the disease, or complications that our shock, or heart failure. List only one cause on each scations that caused the peath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Year Dav Pregnant at time of death 1 Yes 2 L 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Hospital or Attending Physician: The 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 🗹 No Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 Tes 2 No Accident Investigation Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens For State Registrar 32642 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Joseph Allen Broadwater Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Allegany Cumberland WMHS Regional Medical Center Age (In yrs. last birthday) 55 Yrs. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 - F Days Hours Jan. 27 ^{ea}1956 Pennsylvania Director 218-64-9520 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 🗌 Yes 2 🔀 No MD Garrett Grantsville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21536 3881 Bear Hill Rd. rral", or items? 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ò 1 X Never Married 2 Married 1 Yes If Yes, Give 2 X No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Divorced Specify: White Year or Dates 27 is marked other than "nature traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry Garrett County (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. Roads Department Truck Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Betty Wiley Alonzo Broadwater and 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 21536 P.O. Box 91, Grantsville, MD Bonnie E. Resh/Sister other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State Grantsville Cemetery Oct. 6, 2011 Grantsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Newman Funeral Homes, P.A. 21. Signature of Funeral Service e Licensee ·Lew P.O. Box 275, Grantsville, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Exami the burial-transit and Due to (or as a consequence of): iding physiciar Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy signed by the atter in the past 12 months? Pregnant at time of death Month Day Year 5 Other (specify) 1 Yes 2 No P.O. Part II. Other significant conditions contributing to death but ript resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Vunknown Completed page 2 should been erlide mig 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy To the Funeral Director; After this certificate I completed filled in by the funeral director, pag 1 Yes 2 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🔀 No 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No after death 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) within 24 hours a To the Funeral D 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gertifying Muria Practioners To the best of my knowledge death occurred at the time. Jake and due to the request) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) e cer

Registrar

State

Muliamma

completed cause of death (Item 23a) (Type, Print

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland / Depart Registrar State of Maryland / Depart Certifi	ment of Health and N icate of Death	ental Hygien Reg. N		32643	
	Physicia Medic		1. Decedent's Name (First, Middle, Last) Ruth Marion Bosley		2. Date of Death September		3. Time of Death 5:11 P M	
Ì	Examir		234 Main St	Westernport	4	c. County of Death Allegany		
	Funeral Director			Under 1 Year If Under 24 Hrs. onths Days Hours Min.	8. Date of Birth (Month, Day, Year) OCL 21	9. Birthpl	ace (State or Foreign and	
	aryland a-f show fied at	ector		rnport		10	od. Inside City Limits 1 Yes 2 □ No	
1	itn the Mi 23a or 28 st be noti	Funeral Director	10e. Street and Number 234 Main St	0f. Zip Code 21562		Ditizen of What Count	ry?	
9036	permit. Fage I and Z should be filed within 72 hours after death with the Maryland department of Health and Mental Hygiene. Inportant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.			Decedent of Hispanic Origin? (Spess, specify Cuban, Mexican, Puerto Yes 2 XNo Specify:	ecify Yes or No- Rican, etc.)	14. Race - America Black, White, et Specify: Wh		
Baltimore, Maryland 21215-0036	within 72 not giene. ier than "nati t, the Medica	Completed by		s Usual Occupation of work done during most of worki OT use retired) ET	ng [iber Manufacturer		
yland	d be filed Mental Hy arked oth atic event	To Be		18. Mother's Name Alic	e (First, Middle, Maider Ce Kohne	n Surname)		
, Man	a 2 shoul ealth and I n 27 is mi	- 5	19a. Informant's Name/Relationship (Type, Print) Cynthia Gerst/ daughter 19b. Mailing A 7928 S	or Town, State, Zip Co Maryland 2	21222			
imore	Fage 1 and nent of Hea ant: If item iry or othe		20a. Method of Disposition 1	ry or other place)	20c. 1/2011 Wes	Location - City or Tov sternport,	vn, State Maryland	
Balt	Departing Import any inj			me and Address of Facility Boa Church St, West			21562	
\rightarrow	nysician/ Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Congestive He Due to (or as a consequence of):		or respiratory arrest,		Approximate Interval Between Onset and Death YEARS	
60 ate be executed	ysician and e burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or iniquiry that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):					
Box 687	y the attending phys ched for use as the	/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ec 4 ☐ Pregnant at time of death 5 ☐ Otto 9 ☐ Unknown	topic pregnancy her (specify)		23d. Date of deliver	y Day Year	
S, P.O.	been signed by the should be detached		Part II. Other significant conditions contributing to death but not resulting in the under morbid obesity, hypertension	lying cause given in Part I.		use contribute to the		
DIVISION Of VITAI RECORDS, tal or Attending Physician: The law requires	sate has been page 2 shoul	Completed by	hyperlipidemia		24a. Was an autopsy performed?	24b. Were autops	sy findings available apletion of cause of	
Vital vsician:	this certificate al director, pag		25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3	26. Place of Death (Check				
ION OF	eath. or: After th				28d. Describe how inju			
DIVISI ital or Att	urs after d ral Direct lled in by t		3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, 1 building, etc. (Specify)	actory, office	28f. Location (Street a City or Town, Stat		Route Number,	
the Hosp	within 24 hours after death. To the Funeral Director: After this completed filled in by the funeral d	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occu Check only one) Certifying Nurse Practioner: To the best of my knowledge, death	on, in my opinion, death occurred at occurred at the time, date and place	the time, date and place, and due to the cause	ce, and due to the cause e(s) and manner as stat	se(s) and manner stated. ted.	
٥	To CO		29b. Signature and title of certifier When he was a signature and title of certifier.	29c. License number 08185WV	29d. D Se g	ate signed (Month, Di ptember 29	ay, Year) , 2011	
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Robert Bess, 122 Ashfield St, Piece	mont, WV 26750				
	Stat Registra	_	31. Date filed (Month, Day, Year) SEP 2 9 2011					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Menth 043 Walter Merle Bryant Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Allegany WMHS Regional Medical Center Cumberland Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign Feb. Droyear 1928 New Hampshire 1 X M 2 🗆 83 Director 021-22-4706 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Garrett Grantsville 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 246 Killdeer Lane 21536 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Korean Black, White, etc. Completed by 1 Never Married 2 🕱 Married XYes Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates. White 3 Divorced 4 Divorced War 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Niagra Mohawk Elementary/Seconday (0-12) College (1-4 or 5+) Chemical Engineer Power Corp. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Harold Bryant Dorothy Sawyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria E. Bryant/Wife 246 Killdeer Lane, Grantsville, MD 21536 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Dale Cemetery Sept. 30, 2011 Salisbury, PA 22. Name and Address of Facility Newman Funeral Homes, P.A. 21. Signature of Funeral Service Licenses dy ellmae P.O. Box 275, Grantsville, MD 21536 23a. Part 1. Enter the disease, or comilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Coros Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir Cause (Disease or iinjury that initiated events burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical that the death certificate be Box 68760 attending pl IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Dav Year Pregnant at time of death 1 Yes 2 L 9 Unknown Yes 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying fause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No 2 No 1 Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? of Vital the funeral director, Be 26. Place of Death (Check only one) Hospital Other: 2 7 No 1 Yes 2 1 npatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 5 Pending (Month, Day, Year) Division 2(Accident Investigation M 1 Yes 2 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined building, etc. (Specify) Medical 29a. Certifier Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of o 29c. License number

DHMH 17 Rev 7/2009

Registrar

21502

Mark Nelson, M.D., 12502 Willowbrook Rd., Cumberland, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 32645 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day 2011 Melvin Arthur Butler 09 24 9:10 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 19 Butler Drive McHenry Garrett Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign Hours 1 X M 2 🗆 F (Month, Day, Year) 03 07 1954 $\stackrel{Coun}{
m MD}$ Director 218-64-7639 57 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Garrett McHenry 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 19 Butler Drive 21550 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?

1 Yes 2 No þ Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give Specify. 3 Widowed 4 Divorced Completed Year or Dates White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 building stone mason Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Orvil Truman Butler Thelma A. Ferguson 19a. Informant's Name/Relationship (Type, Print) Sylvia J. Butler-wife 19 Butler Drive, McHenry, MD 21541 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayard Cemetery 9/27/2011 Bayard, WV 22. Name and Address of Facility David, A. Burdock Funeral Home PA 21 N 2nd St, Oakland, MD 21550 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) Lung Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Due to (or as a consequence of) -tran and that initiated events resulting in death) Last Due to (or as a consequence of): ng physician a as the burial-t Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month 5 Other (specify) Day Year Pregnant at time of death the g Unknown Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy nerform 1 Yes 2 No 124 hours after councille.

e Funeral Director: After this certifical letted filled in by the funeral director, particularly. or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Tes Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town. State) To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) H26154

Registrar
DHMH 17 Rev 7/2009

State

69 Wolf Acres Drive, Oakland, MD 21550

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

. Registr

P. Daniel Miller,

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygien ? Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ SEPTEMBER D24 2011 7:25 A M ELIZABETH KAY BOWERS Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b, City, Town, or Location of Death 4c. County of Death FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK Social Security Number 7. Age (In yrs. last birthday) 61 yrs. If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 9. Birthplace (State or Foreign 219-54-0729 1 □ M 2 😿 F Country) 1997 71 950 Director Usual Residence of Decedent 28a-f shov 10a. State with the Maryland 10b. County 10c. City, Town or Location Examiner must be notified at **Funeral Director** 10d. Inside City Limits MD Frederick Myersville 1 Yes 2 No ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 3235 Brethren Church Rd. 21773 USA items death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinone. Black, White, etc. þ 1 Never Married 2 🛣 Married 1 Yes X No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) waitress restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Charles Ellsworth Wiles Lucille Bowser 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21742 19a. Informant's Name/Relationship (Type, Print) Lisa Montgomery (Daughter) 13112 Hepplewhite Circle, Hagerstown, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 2
Cremation 3

Removal from State 9/28/2011 Middletown, MD Conation 5 Other (Specify) Lutheran cemetery: un al Srvice L Donald B. Thompson Funeral Home Middletown, MD 21769 Part 1. Enter the disease, or comp s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or neart failure. List only or Immediate Cause (Final CORONAR Due to (or as a consequence of): Onset and Death Physician/ disease or condition resulting in death) ARTERY 015EAVE Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Dub to for us a consequence of: -transit Exami law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of): burial physician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending physical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Pregnant at time of death Year 1 ☐ Yes ∠ ₹ 9 ☐ Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ENSION CHRONIC 1 Yes 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should I 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performed 2 No Yes 2 No 1 🗌 Yes Hospital or Attending Physician: 1 24 hours after death. Funeral Director: After this certifica eted filled in by the funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Hospita Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes မ 1 1 Inpatient 2 🗆 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury Certificate; 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending ☐ Accident☐ Suicide 1 Tes 2 No Investigation 6 Could not be To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by the 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

State

6

Registrar

Medical

(Check

ANDREN JONELSON 32.

Signature and title of certifier

65C MD €egistrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7740 mas COMMON DR, FREDERICK

29d. Date signed (Month, Day, Year)

Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number **36**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 🤊 🕦 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1105/51/60 Physician/ 4:56 AM Shirley Barbour Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince Georges Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗌 F Months Hours Min. 04/14/14/24 Yrs Director 577-44-1672 83 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No DC Washington r items 23a or ner must be n 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5101 Fitch St., SE apt.102 20014 AZU 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, r than "natural", or iter the Medical Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify. Specify: Completed 3 Widowed 4 X Divorced Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 75 Truck Driver Transportation permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ည Virginia Plunkett Alex Barbour 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra L. Moses / niece 7204 Allentown Rd., Ft. Washington, MD 20744 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Harmony Memorial Cem- 09/27/2011 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Landover 1 MD 4 Donation 5 Other (Specify) Strickland Funeral Services 21. Signatur (g) Funeral Septice Licens 22. Name and Address of Facility 6500 Allentown Rd., Camp Springs, MD 20748 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final h sician/ Acros Atheroscierune Cardiovascular chisease disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner typevtensia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Ducito for as a consequence uniand -transit Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) burial-Physician/Medical Box 68760 attending pl for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death Dav 9 Unknown g Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CIYVLUSI'S 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ → known Completed As whs. 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed 1 Yes No Aorhe valvo ve placemen Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Deat 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural 2 Accident 5 Pending after death. Director: Af 1 Yes 2 No Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 only one) 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number mil K Max 77 MD D50689-09/19/2011

State Registrar 31. Date filed (Month, Day, Year)

canten

MD

Minon

20775

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANILE MATA AD AND. Syrvetten Roan.

32. Registraris Signat

7503

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #25, per me, g934 12-17-12 sm State of Maryland / Department of Health and Mental Hygiene For State Registrar 32648 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 11:30P M [™]869/24/26√11 Jack Cary Cohen Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Bethesda Suburban Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country DC Social Security Number Sex 1X M 2 □ F . Age (In yrs. last birthday) **Funeral** Days Hours Months 0671371924 **Director** 87 579 09 4123 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Bethesda MD Montgomery 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral United States 20817 7000 Crail Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian. Armed Forces? Black, White, etc. "natural", or Completed by 1 Never Married 2X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced 1946 other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DONOT use retired)

Architect than, △ College (1-4 or 5+) Commercial/Residential Elementary/Seconday (0-12) and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Nettie Cohen Harry Cohen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 7000 Crail_Drive Bethesda, MD 20817 Sally R. Cohen/Wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 🗌 Burial 2 🏋 Cremation 3 🗌 Removal from State 09/28/2011 Falls Church, VA National Crematory 4 Donation 5 Other (Specify) 22. Name and Address of Facility Joseph Gawler's Sons, Inc. Signature of Fungral Service Licensee 20016 Washington, DC 5130 Wisconsin Ave., NW 23a. Part 1. Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failers. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Pontine Bleed Non Traumatic disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner PROVED BY MEDICAL EXAMINER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last CERTIFICA Due to (or as a consequence of) physician s the burial Physician/Medical Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ___ 1 ☐ Live Birth 4 ☐ Pregnant a g ☐ Unknown in the past 12 months? Day Year Month Pregnant at time of death Yes 2 No signed by the a d be detached f 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performer? To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director. After this certificate has t completed filled in by the funeral director, page 2 s Yes of Vital 25. Was case referred to medical 26. Place of Death (Check only one) To Be examiner? Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) 1 X Yes 2 Xivo 1 K Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending Division 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 24 09/27/2011 D70027 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Old Georgetown ROAD BETHESDA, MO Amsler MD

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

28

backer

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Calevas Harry Sept 26,2011 2:10am M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Bethesda 4920 Sentinel Dr #104 6. Sex 1 **X** M 2 □ F 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign Funeral 577-03-4186 Days Min Jan 1912 Norfolk, VA **Director** 99 Yrs. Usual Residence of Decedent 23a or 28a-f shov 10d. Inside City Limits "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location Director Bethesda Montgomery X☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 4920 Sentinel Drive #104 20816 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🐼 No Black White etc þ 1 Never Married 2X Married within 72 hours after 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: White 3 Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Lawyer Law Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Ellen Koloua Anathanassios Calevas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 4920~Sentinel~Dr,~#104~Bethesda,~MD~~20816Denise Calevas/Wife 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 9-29-2011 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery Brentwood, MD Joseph Gawler's Sons, INC 22. Name and Address of Facility 5130 Wisconsin Ave, N.W. Washington DC 20016 23a. Part II. Enjer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Congestive Heart Failure Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Aortic Stenosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physicial Physician/Medical as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? ō Month Day Year Pregnant at time of death 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Coronary Artery Disease 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 24 page 2 certificate ☐ Yes Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home P Residence 6 Other (Specify) 1 🗌 Yes 2**X** No ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 XNatural To the Hospital or Auterians, within 24 hours after death.

To the Funeral Director: Aft 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and tit 29d. Date signed (Month, Day, Year) 29c. License numbe 10 D07147 Sept 26,2011

Registrar
DHMH 17 Rev 7/2009

State

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

5550 Wisconsin Ave, Chevy Chase, MD #700

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

37. Registrar's Signature

Allen Nimetz, M.D.

28 201

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month 1230 PM Raymond Garfield Campbell. Sr. 2011 Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Hagerstown Washington County Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 7. Age (In vrs. last birthday) 1 XM 2 □ F April 16, **Director** Maryland 213-40-3111 68 1943 Usual Residence of Decedent 28a-f show 10a. State items 23a or 28a-f sho her must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington County Hagerstown 1 X Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 920 Corbett St. 21740 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, item 27 is marked other than "natural", or iter other traumatic event, the Medical Examiner Completed by 1 Never Married 2 Married Yes Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 X Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Fork Lift Operator 12 Automobile Mfg. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filed and Mental H Albert Campbell Jane Dorsey Campbell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 sl of Health a item 27 i Clara J. Broadus-sister 462 Park Place Hagerstown, MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 Department of of Important: If it any injury or o X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Rose Hill Cemetery 9-27-2011 Hagerstown, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter to disease, or or implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or to retailure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) 10 tro 210 Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Exami Due to (or as a consequence of): nding physician use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? After this certificate | funeral director, page 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) No Hospital Other: 1 🗌 Yes ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Date of injury (Month, Day, Year) 27. Manner of Death e Hospital or Attending Pl 124 hours after death. e Funeral Director: After th 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident
Suicide
Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) m os C 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 580C

Registrar DHMH 17 Rev 7/2009

State

filed (Month, Day, Year)

Box 68760

P.O.

Records,

Division of Vital

32. Registrar's Signature

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend item 5 per inf g920 10-19-11 vt
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 32651 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 7:00 A DEBORAH COTTMAN 2011 Medical Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death Wicomico the at Social Security Number 212 55 1484 8 Date of Birth 9. Birthplace (State or Foreign If Under 24 Hrs 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Month, Day, **B** 28, 1 🗆 M 2 🗶 F Months Yrs 60 DELAWARE Director FEB Usual Residence of Decedent 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director MARYLAND WICOMICO 1 X Yes 2 □ No SALISBURY 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? Examiner must be Funeral 23a 804 COLLEGE LANE, APT. A 21804 UNITED STATES items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. ō þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. "natural", Specify: BLACK 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) PHARMACEUTICAL MFG. event, the 12 LINE LEADER TECHNICIAN Be 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) is marked o ပ FRANKLIN CORBIN **ELIZABETH DENNIS** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. CLIFFORD T. COTTMAN (HUSB.) 804 COLLEGE LN., APT. A SALISBURY, MD 21804 20a. Method of Disposition 20h. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) Page 1 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) FIRST STATE CREM.CTR. OCT 3,2011 MILLSBORO, DE 21. Sin ature of 22. Name and Address of Facility MO 1361 WATSON FUNERAL HOME PO BOX 125 MILLSBORO, DE Vications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest the cause on each line. 23a. Part 1. Enter the disease, or complishock, or heart failure. List only one Interval Between Immediate Cause (Final Onset and Death Ph_sician/ MALIGNAN LUNG CARCINDUMA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or iinjury that initiated events -transit and Due to (or as a consequence of): resulting in death) Last physician a Physician/Medical certificate be P.O. Box 68760 attending ph IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death the 9 Unknown detached g Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should been s 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perforn death? this certificate Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Fother (Specify HOSPICR မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: To the Funeral Director: After I completed filled in by the funera To the Hospital or Attending Natural 5 Pending injury 1 ☐ Yes 2 ☐ No death 2 Accident 3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide determined hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier within 24 (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1005 8410 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1733 SACGBU HU LAW RA 2 lo 1207

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

SEP 2 9 2011

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death r 24 2011 Physician/ Latrina G. 1400 M Carter September Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 9504 Tunstall Place Montgomery Village Montgomery Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours (Month, Day, Year) **Director** 190-42-0489 1 🗆 M 2 🗶 F 60 April 9 1951 Pennsylvania Usual Residence of Decedent 28a-f shov "natural", or items 23a or 28a-f sho 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Montgomery Village Maryland Montgomery 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20886 9504 Tunstall Place 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 No Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 Divorced Year or Dates African American Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business/Industry (Specify only highest grade completed) f Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) County School System Bookkeeper 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Louise Reid Marv Ralph Carter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marsha Carter / Sister 20210 Maple Leaf Court, Gaithersburg, Md. 20886 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or otl once. Date cemetery, crematory or other place)
Metropolitan Crem. 1 Burial 2 X Cremation 3 Removal from State 9/26/2011 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Name and Address of Eacility, Muriel H. Barber Funeral Home Box 5038, Laytonsville. 20882 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between nset and Dea Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery for in the past 12 months?

1 Yes 2 No
9 Unknown Dav ate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Hospital or Attending Physician: The law this certificate has performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 X Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funer 1 Natural 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of certifie S I MO DONE

Registrar
DHMH 17 Rev 06-2011

State

DME

mo,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State of I	Marylan	-	artment of H		-			00050
			Registrar 1. Decedent's Name (First, Middle, Last)		Cer	tificate of D	eath		Reg. No.		32653
	Physicia Medic		Clarence Leon Carroll	, Jr.				2. Date of De Month Septen		3 2011	3. Time of Death 1:25A M
	Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or				unty of Deat	th
أرسيب			Manor Care Potomac			Potoma				ontgon	
	Funeral Director		579-50-3822 1 X M 2 □ F	Age (In yrs. Ia 74	ast birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Bir (Month, Da Jan	th <i>y, Year)</i> 5 193	Co	thplace (State or Foreign untry) Maryland
	nd now at	٦	Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Lo	cation					10d. Inside City Limits
	anylar ta-fsl	Director	Md. Montgomery	1	_	Potomac					1 ☐ Yes 2 🇷 No
	or 28	ä	10e. Street and Number			10f. Zip Code		Т	10g. Citizer	of What Co	ountry?
	s 23a	Funeral	9 Deborah Court			208	354		Uni	ted Si	tates
	death item		11. Marital Status 12. Was Deceder Armed Forces	-2	1	Vas Decedent of His f Yes, specify Cubar	spanic Origin? (Sp n. Mexican, Puert	pecify Yes or No- o Rican, etc.)		Race - Ame Black, Whit	erican Indian,
336	al", or Examin	d by	1 Never Married 2 Married 1 Married	\square No 19	957 – 1	I ☐ Yes 2 ☑ No		,			nite
9	hours natur dical	Completed	15. Decedent's Education		16a. Decec	tent's Usual Occupa			16b. Kind	of Business	
21	nin 72 ne. han "	ome	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or	or 5+)	life. De	kind of work done do O NOT use retired)		rking			
7	d with tygier ther t	Be C	12 2 17. Father's Name (First, Middle, Last)		l M	letrologis					ernment
lanc	be file lental H rked o tic eve	일	Clarence L. Carroll, Sr	•				ne <i>(First, Middl</i> e, rine M.			
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Inmportant: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type, Print) Ann F. Carroll / Wife			ng Address (Street a				vn, State, Zi _l 20854	p Code)
Baltimore,	e 1 and t of Hea If item or other		20a. Method of Disposition 1 ☐ Burial 2 🏿 Cremation 3 ☐ Removal from Sta			sition (Name of natory or other place	a)	Date	20c. Locat	ion - City or	Town, State
tim	tt. Pag rtmen rtant: rjury (4 Donation 5 Other (Specify)			tan Crem.		4/2011			a, Virgin <u>ia</u>
Bal	Depar Impo any ir		21. Signature of Funeral Service Licensee	7		Name and Address O Box		Muriel F Laytonsv			uneral Home 20882
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
₽	Physician/ Medical		moulting in dooth)		Absce	ess					Onset and Death
	Examiner		Due to (or a								
	sd sit	Examiner	cause. Enter Underlying	ıs a consequ	ence of):						
	cate be executed physician and s the burial-transit	Еха	that initiated events c. Due to (or a	ıs a consequ	ence of):						
260	te be e nysicia ne buri	edical	d								
3876	irtifical ling ph e as th	/Me	IF FEMALE:								
Box 68	ath ce attend for us	cian.	in the past 12 months?	n 2 🗌 Feta	I death 3	Ectopic pregnancy Other (specify)	,		23d	Date of de Month	livery Day Year
Ö.	y the a	Physician/M	1 Yes 2 No 4 Pregnan g Unknown 9 Unknown		ieatii 5 L	Other (specify)					
P.O.	that the properties that t	by P	Part II. Other significant conditions contributing to death	but not resi	ulting in the u	nderlying cause give	en in Part I.	23e. Did t	obacco use o	contribute to	the cause of death?
ds,	quires en sig ould b		Coronary Artery Disease					1 🗆	Yes 2 1	10 3 □ P	robably 4 🗹 Unknown
SO.	law re las be e 2 shr	Completed	Staghorn Calculus					24a. Was	osy	prior to	topsy findings available completion of cause of
Be l	sician: The la certificate ha irector, page 2		Chronic Kidney Disease					perfo 1 ☐ Yes	rmed? 2 ☑ No	death?	s 2 No
ıta :	sician certifi rector	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:			Other	ce of Death (Che				
<u>,</u>	y Pnyser this eral di	e: To	27. Manner of Death 28a. Date of ir	njury	ER/Outpatien 28b. Time of	28c. Injury	4 El Nursing F at	lome 5 Resid			cify)
on	ending sath. or: Afte he fun	ficat	1 🔀 Natural 5 □ Pending (Month, D 2 □ Accident Investigation	Jay, Year)	injury	M 1 □ \	/es 2 □ No				
Division of Vital Records, P.O.	al or Aft safter de l Directe d in by t	Certificate:		njury - At ho etc. <i>(Specify)</i>		eet, factory, office		28f. Location (S City or Tox		ımber or Ru	ral Route Number,
-	To the Pospital or Attending Prysician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 X Certifying Physician: To the best of Check 2 Medical Examiner: On the basis of	f examination	and/or invest	igation, in my opinior	, death occurred	at the time, date a	ind place, and	d due to the	cause(s) and manner stated.
į	vithin o the comple	Σ	only one) 3 L Certifying Nurse Practioner: To the 29b. Signature and title of certifier	ne best of my	knowledge, c	leath occurred at the 29c. License		ace, and due to th	e cause(s) an 29d. Date si		
	- I- U		Thomas Master	son	MS	D5053	34				23, 2011
	30%		30. Name and address of person who completed cause of	death (Item	23a) (Type, P		<u> </u>				0010-
			Thomas Masterson, M.D.		4 /	i Dominio	n Dr., #	104, M	cLean,	Va.	22101
	Stat Registra	e	31. Date filed (MoSEP, 2017 2011 32 Regis	trar's Signati	U. So	who					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 22, 2011 Clark Nancy Marie 10:30 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick Northampton Manor Nursing Home If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖾 F Months Hours Min. 578-64-6867 April Day Year) 1947 64 Washington, D.C Director Usual Residence of Decedent 28a-f show at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified Frederick Maryland Frederick 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral United States 21702 7121 Rock Creek Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XX No Specify: White "natural", Completed 3 Widowed 4 X Divorced Year or Dates 1 and 2 should be filed within 72 hours of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Retail 12 Human Resources Administrator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Rosenna Gray Esmond Miller Jage 1 and 2 showers and 2 showers any injury or other any or other any or other any or other any or other 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip C 2616 N. Everly Drive, Frederick, MD 21702 Scott Clarke / Son 20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town. State Date 23. Sept. 1 🗆 Burial 2 🖾 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Frederick, Maryland Resthaven Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2011 21. Signature of Funeral e Licensee Skkot Cody P.A. Frederick, MD 21701 Resthaven Funeral Services, Catoctin Mountain Hwy. 23a. Part 1. Enter the disease complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. Ast only one caus Immediate Cause (Final disease or condition resulting in death) Onset and Death REAST Physician/ Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter orderlying Cause (Disease or iinjury Due to (or as a consequence of) Examir the Hospital or Attending Physician: The law requires that the death certificate be executed ng physician and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 M No Month Year Pregnant at time of death Day 1 ☐ Yes ∠ ↓ 9 ☐ Unknown been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖬 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an has page 2 autopsy performe death? this certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes Other: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending within 24 hours after death. To the Funeral Director: A 1 🗆 Yes Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. le of certifier

DHMH 17 Rev 7/2009

10

State Registrar Recompleted cause of death (Item 23a) (Type, Print)

egistrar's Signature

BOCARUM

LIVE, PREDELICE, MD 21702

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 32655 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Charlena September 28. Medical Elizabeth Crawford 2011 8:17a M 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Manor Care Montgomery County Bethesda **Funeral** 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 XF Months Days Hours **Director** 167-12-2215 04-24-1924 87 Atlanta Georgia Usual Residence of Decedent ms 23a or 28a-f show must be notified at ould be filed within 72 hours after death with the Maryland of Mental Hygiere.

marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1

Yes 2 □ No Md. Silver Spring 10e. Street and Number 10g. Citizen of What Country? or items 23a Funeral 531 Randolph Road, #130A 20904 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. permit. Page 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any Injury or other traumatic event, the Medical Examiner I 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black Completed 3 XWidowed 4 Divorced Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 7th Food Service Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alex Parks Ella Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gwendolyn Calhoun - Daughter 531 Randolph Rd., #130A Silver Spring, Md. 20904 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Washington Nat'l Cem. 10-07-2011 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatar of Funeral Service U 22. Name and Address of Facility Ronald Taylor II Funeral Home 10583 Middleport Lane, White Plains, Maryland 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death uraemia Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** diseas nacione Sequentially list conditions, if any, leading to fining-drate cause. Enter Underlying Cause (Disease or impury Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death ed by the a 9 Unknown certificate has been signed by rector, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Nown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 No 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 🗷 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) မ 1 🗆 Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work Accident 1 Yes 2 🗌 No Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier only one) 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie D0054566 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CLEORGIN ANNIES #1-17 Silverspring Sunitha Bhogarili

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year) SEP 3 0 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 24, Physician/ 2011 Viola Charles 9:51 Рм Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's 10426 Knollwood Court Adelphi 8. Date of Birth (Month, Day Year) March 22, 1936 Funeral Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 1 □ M 2 [XF Months Days Hours Director South Carolina 224-50-0478 75 Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at death with the Maryland 10b, County 10c. City, Town or Location 10d. Inside City Limits Director Adelphi 1 Yes 2 No. Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10426 Knollwood Court 20783 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces þ Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examir 1 Never Married 2 Married ☐ Yes 2 🔼 No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: African If Yes, Give Completed 3 X Widowed 4 ☐ Divorced Specify: Year or Dates American 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Child Care Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Simon Hampton Isabelle Reed 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20783 Deborah Charles- Daughter 10426 Knollwood Court Adelphi, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State October 3, 2011 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road NE Washington, DC 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Metas disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of) cause. Enter Underlying that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last physician ar s the burial-t Due to (or as a consequence of): by Physician/Medical Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months 1 Yes 2 No Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hospital or Attending Physician: The law requires Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Daughter's Residence examiner? 1 🗌 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Mann Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred VNatural 5 Pending 24 hours after death Funeral Director: A Accident 1 Yes 2 🗆 No Investigation Could not be within 24 hours after dex To the Funeral Directon completed filled in by th Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State; Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

30. Name and address of person who completed cause of Seath (Item 23a) (Type, Print)

RABINDRA PAUL, MD, 1160 VARNUM ST, NE, SUITE 302, , 1160 RABINDRA SEP 3 0 2011 32. Regist Ar's Signature 31. Date filed (Month,

29b. Signature and title of certifier

Registrar

MD 037243

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

Amend #9 per Ith G920 10020/11 dk
State of Manyland / Department of Health and Montal Hygiene

			For State Registrar		State of IVI	aryland	-	rtment of			іептаі Ну	'gien Reg. N	-201	3	3265	7
	Physicia			e (First, Middle, Las Derikow	,						2. Date of De Month Septeml		^{Day} 20, 2 ^{Year} 201		Time of Death	
	Medi Examii		4a. Facility Name (if	not institution, give	street and number)			4b. City, Town		of Death	Версен		4c. County of Dea		10.501	
	<i>2</i>		Manor Ca 5. Social Security No		ng Home of		nesda st birthday)	If Under 1 Ye	Bethes	er 24 Hrs.	0 D-t (D)	-11-	Montgor		(0) 1 = 1	_
	Funeral Director		577-64-3 Usual Residence of	3783 ¹	M 2 X F 7. Age	81	Yrs.	Months Day		Min.	8. Date of Bir (Month, Da April 2	v. Year	1930	ountry)	(State or Foreign	
	land show dat	tor	10a. State	10b. County		10c. City	, Town or Loc	ation						10d. lr	nside City Limits	_
	Mary 28a-f notifie	Director	MD	Montgo	mery	I	Bethes								☐ Yes 2X No	,
	with the 23a or	Funeral [10e. Street and Nun 5101 Ric	_{nber} lgefièld [Road			10f. Zip Cod 208					Citizen of What C USA	ountry?		
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	百	11. Marital Status 1 ☐ Never Marri 3 🏋 Widowed	ied 2 ☐ Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ I If Yes, Give Year or Dates.			as Decedent of Yes, specify Co			cify Yes or No- Rican, etc.)		14. Race - Am Black, Whi	te, etc.		
2-0	hours "natur dical B	olete		15. Decedent's E	ducation	- 1		ent's Usual Occ ind of work dor		at of wartin		16b.	Kind of Business			
Maryland 21215-0036	thin 72 ene. than '	Completed	Elementary/Second		College (1-4 or 5-	+)	life. DC	NOT use retire	ed)	St OI WOIKIII	ig		O II -			
<u>1</u>	iled wi I Hygiv other vent, t	Be	17. Father's Name (I			l		<u>Iomemak</u>		her's Name	(First, Middle,	Maide	Own Horn n Surname)	ne		-
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Jan	shou and is m		19a. Informant's Na		,		I .						or Town, State, Z			
	and 2 Health tem 2		DougLas 20a. Method of Disp		Attorney	20h Pla		irthous	e Squa		Suite 2		Rockvil Location - City o			0
ШÕШ	Page 1 nent of nt: If ii				Removal from State	ce	metery, crem	atory or other p		_		l	ntwood,			
Baltimore,	permit. I Departrr Importa any inju		21. Signature of Fur				22.	Name and Add	ress of Facil	lity Si	mple T	rib				_
			23a. Part 1. Enter the	he disease, or comp	plications that caused ne cause on each line.	the death.							ie, mary	Appi	roximate	7
2	Pnysician/ Medical		Immediate Cause (I disease or conditio resulting in death)	Final	a Failur			<u> </u>							val Between et and Death	
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092	icate be executed physician and is the burial feature.	Aedical			d. Loss o	Eapp	etite							_		_
. Box 68	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending p completed filled in by the funeral director, page 2 should be detached for use as t	I	IF FEMALE: 23b. Was decedent in the past 12 n 1 Yes 2 X g Unknown	nonths?	23c. If yes, outcome o 1 Live Birth 2 4 Pregnant at 9 Unknown	☐ Fetal	death 3 🗌	Ectopic pregna Other (specify)					23d. Date of de Month	elivery Day	Year	
P.O.	s that the gned by be detac	by Pt	Part II. Other signifi	icant conditions co	ontributing to death bu	t not resul	Iting in the un	derlying cause	given in Part	t I.			use contribute t			
rds	equire	eted											2 No 3 I			
} ital Records,	The law i	Completed											prior to death?	completi	ndings available ion of cause of No	
ta	ician: certific ector,	BB	25. Was case referre examiner?		Hospital;				Place of Dea		, ,					
#5 5>	g Phys er this eral dii	e: 10	1 X Yes 2 2 27. Manner of Death		28a. Date of injury	. 2	R/Outpatient 28b. Time of	28c. Ini	4_XN uryat		ne 5 🗌 Resid Bd. Describe h		6 Other (Spe	cify)		_
# ouo	ending eath. or: Afte he fund	ficat	1 Natural 2 Accident	5 Pending Investigation		Year)	injury	l w	ork? □ Yes 2 □	- 1	34. 2000/1201	ion inje	ary occurred			
# Division of	al or Atte	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injur building, etc.		ne, farm, stree	t, factory, offic	9	2	8f. Location (S City or Tow		nd Number or Ru e)	ural Route	e Number,	
_	ne Hospi in 24 hou ne Funera pleted filk	Medical	(Check 2	Medical Exami	sician: To the best of mer: On the basis of exa e Practioner: To the b	mination a	and/or investig	ation, in my opi	nion, death o	occurred at the	he time, date a	and plac	e, and due to the	cause(s)	and manner state	d.
	vith To t		29b. Signature and t		Voh	g	MI	29c. Licer	se number			29d. D	ate signed (Moni	h, Day, Y	ear)	
				ess of person who cover Vohra, M.	ompleted cause of dea					a, Ma	ryland			-		_
	Stat Registra	-	31. Date filed (Month		22. Registrar	0: .										_

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1- For State of Maryland / Dep	ertificate of Death	Reg.	2011	32658
	Dhysisi	on	1. Decedent's Name (First, Middle, Last)		Date of Death Month	Dav Year	3. Time of Death
	Physici /Medi		Julia Marie Davis	T	September		9:35 P ^M
	Examir	ner	4a. Facility Name (If not institution, give street and number) Homewood at Williamsport	4b. City, Town, or Location of Death Williamsport		4c. County of Death Vashing ton	
	Funeral Director		5. Social Security Number 577-28-4523	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye June 21, 1	ar) 9. Birth Coul 1923 Mary	place (State or Foreign ntry) Land
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation		1	0d. Inside City Limits
	the Marylar 28a-f show	tor	Maryland Washington County Hagersto	wn			1 □Yes 2 No
	or death with the Maryla tems 23a or 28a-f sho	al Dire	10e. Street and Number 11925 Robinwood Dr.	10f. Zip Code 21742	-	Citizen of What Cour	ntry?
980	thould be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "naturat", or items 23a or 28a-f show marked other than "naturat", or items 23a or 28a-f show marked other than "naturati	Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Spilf Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: Wh	
21215-0036	72 hou natura	eted	15 Decedent's Education 16a Dec	edent's Usual Occupation	16b	. Kind of Business/In	dustry
121	within ene. than "	dmc	Elementary/Secondary (0-12) College (1-4or 5+)	skind of work done during most of worki DO NOT use retired) nistrative Assista		ood Wareho	use
102	filed Il Hygi other rent, t	Be Co	17. Father's Name (First, Middle, Last)		e (First, Middle, Maid		
Maryland	uld be Menta arked artic ev	10 B	John J. Miles Sr.	Beatrio	ce Rose Hu	ıghes	
lar)	2 sho and is ma	ľ		ing Address (Street and Number or Rura		-	
	1 and Health em 27			25 Robinwood Dr. Ha		, MD ZI/42 Location - City or To	
Baltimore,	permit, Pages 1 and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i any Injury or other traumatic event, the Medical Exercisions.		1 XBurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Fort Lin	9 - 2011 Br	entwood,	Maryland	
Bal	Depar Impor any Ir			2. Name and Address of Facility ${f Doug}$			
	Physician /Medical		23a. Part 1. Enter the disease, or complications that caused the de th. Do not er shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		or respiratory arrest,		Approximate Interval Between Onset and Death
7	Examiner		प्रक to (or as a consequency को):	my Diceser		Ī	PETINDE
	pe sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c			-	
	ficate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events c			1/4	
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	rtificat ng phy as th	Medical	IE EEMALE.				
P.O. Box	Attending Physician: The law requires that the death certificate be executed stroked. It death, Exercises the sertificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the buriat-transit.	Physician//		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delive Month	ery Day Year
	w requires that been signed should be det		Part II. Other significant conditions contributing to death but not resulting in the conditions to the significant conditions contributing to death but not resulting in the conditions contributing to death but not resulting in the conditions contributing to death but not resulting in the conditions contributing to death but not resulting in the conditions contributing to death but not resulting in the conditions contributing to death but not resulting in the conditions contributing to death but not resulting in the conditions contributing to death but not resulting in the conditions contributing to death but not resulting in the conditions contributing to death but not resulting in the conditions contributing to death but not resulting in the conditions contributing to death but not resulting in the conditions contributing to death but not resulting in the conditions contributing to death but not resulting in the conditions contributing to death but not resulting in the conditions contributing to death but not resulting in the conditions co	anderlying cause given in Part I.	23e. Did tobaca	co use contribute to t	he cause of death?
I Records,	: The law re cate has be page 2 sho	Completed by	France DISTORE		24a. Was an autopsy performed	prior to co death?	opsy findings available ompletion of cause of 2 □ No
Vital	Physician: The this certificate i al director, pago	Be (25. Was case referred to medical examiner?		n (Check only one)	<u> </u>	
of	Phys r this ral dir	۲.	1 ☐ Yes 2 ☐ Yes 2 ☐ Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie 27. Manyfer of Death 28a. Date of Injury 28b. Time 0		me 5 Residence	e 6 Other (Speci	fy)
ion	nding F ith. :: After e funera	ation	1 Matural 5 Pending (Month, Day, Year) Injury 2 Accident investigation	Work? M 1 □Yes 2 □No	200. Describe now i	njury occurred	
Division	al or Atter after dea I Director d in by the	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S	t and Number or Rur tate)	al Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or i and manner stated.	th occurred at the time, date and place, nvestigation, in my opinion, death occur	and due to the caus red at the time, date	se(s) and manner as and place, and due t	stated. o the cause(s)
	To the vithing to the congression of the congressio	M	29b. Signature and tilled Certifier MEDICAL VINCET	29c. Eigense number	29d.	Date signed (Moglith,	Day, Year)
	IW-5		30. Name and address of perion who completed cause of death (Item 23a) (Type TEXTEX (IV) BY2Y FE	Ave Ge 101 to	la constan	a, Mil	2/747
	Sta Registr		31. Date filed (Month, Day, Year) SEP 8 8 2011 32. Registrar's Signature	in	,	,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 32659 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 9/26/2011 John Carl Deck, Jr. 1:12 Α Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Wicomico Peninsula Regional Medical Center Salisbury Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1X M 2 . F Months Days Hours Min. Director Wash. DC 578-34-3096 97 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No DE Sussex Frankford 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral 34702 S. DuPont Hwy 19945 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iten edical Examiner r 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3 Widowed 4 ☐ Divorced Specify: white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) other than " Elementary/Seconday (0-12) College (1-4 or 5+) Accountant private practice ulth and Mental Hygie 27 is marked other r traumatic event, tt Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ <u>John Carl Deck, Sr.</u> Marie J. Hayden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jim Deck (son) 15 54th St. Ocean City, MD 21842 or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2XX Cremation 3 Removal from State 4 Donation 5 Other (Specify) First State Crematory 9/27/2011 Millsboro, DE 21. Signature of Funeral Service icensee 22. Name and Address of Facility The Burbage Funeral Home 108 William St. Berlin, MD 21811 23a. P. 1. Ent. the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sub Dunal Physician/ Hendene disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examiner if any, leading to immediate Due to (or as a consequence of): Cause (Disease or iinjury transi that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 🗌 Yes 24b. Were autopsy findings available 24a. Was an After this certificate has prior to completion of cause of death?

1 Yes 2 No autopsy 25. Was case referred to medical examiner? 26. Place of Death (Check only one) examiner: Yes Hospital Other: 2 No ဂ္ Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at the Hospital or Attending Natural 5 \square Pending 1315 within 24 hours after death.

To the Funeral Director: All completed filled in by the fu 9/21/11 tall @ home 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) determined 5. Duront Hoo Home Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Plactioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature a 29c, License number 29d. Date signed (Month, Day, Year) D 63199. 9/28/11 DME 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) YOG-ENH VOHRA 91。 EASTERN SHORE SAUSBURY, MD. 21804 910 EASTERN SHORE BA

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

2 9 201

Box 68760

P.O.

Division of Vital Records,

backs

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #19b per FH FCHD TM 9/27/11
State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ eptember Daggan 1336 narew 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore 8. Date of Birth (Month, Day, Year) March 3, 1959 Social Security Number **Funeral** Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Months Days 1 **2** M 2 □ F Min. Hours Pennsylvania **Director** 135-44-0093 52 Usual Residence of Decedent show er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 24349 Newbury Road 20882 USA 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Bace - American Indian. Armed Force Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ■ No If Yes, Give þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Mo Specify 3 Widowed 4 Divorced Completed White Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Sales Person Food Service injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should be Department of Health and Ment. Important: If item 27 is mark---any injury or ----Ralph N. Daggan, Jr. Nan Keenan Daggan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn M. Marschall, Wife Road, Gai 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🗆 Burial 2 🖨 Cremation 3 🗆 Removal from State Metropolitan Sept.25,2011

Metropolitan Sept.25,2011

Metropolitan Sept.25,2011

22. Name and Address of Facility
Molesworth-Williams, P.A.,

293 26401 Ridge Road, Damascus, 4 Donation 5 Other (Spec fy) Alexandria, Virginia Funeral Sen Licer see M01393 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition MONARY Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) ate has been signed by the atte page 2 should be detached for a Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 1 Yes 2 No 1 ☐ Yes 2 D No 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other: မ 1 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending iniury Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 SEPTEMBER 20, 2011 61 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 N Wolfest Baltimore CHERUVU 31. Date filed (Mo egistrar's Signature State barker Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September Physician/ Marisa E. Diggs Medical 4a. Facility Name (*if not institution, give street and numper*)
3350 Curtis Drive, Apt. *# 302 Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Suitland Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign 1 ☐ M 2 🔀 F Months Days Hours 01/09/1959 MD **Director** 579-88-6343 52 Usual Residence of Decedent show 10a, State at 10c. City, Town or Location 10d. Inside City Limits Funeral Director must be notified 28a-f MD Prince George's Suitland 1 Yes 2 □ No 10e. Street and Numbe 0 10f. Zip Code 10g. Citizen of What Country? 23a 3350 Curtis Drive, Apt.#302 20746 United States items death ıral", or item Examiner n 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian, Armed Forces?
1 Yes 2 No Black, White, etc. þ 1 A Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", Completed If Yes, Give Specify: Black 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Accountant Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) ပ Franklin A. Diggs Hilda A. Brown and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 7518 Abbington Drive, Oxon Hill, MD 20735 Glennard Walker, Jr. item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Important: If it any injury or o cemetery, crematory or other place 1 KBurial 2 Cremation 3 Removal from State 9/30/2011 Clinton, Maryland 4 Donation 5 Other (Specify) esurrection Cemetery 22. Name and Address of Facility Pope Funeral Homes, P.A. 21. Signature of pheral Service Licensee 5538 Marlboro Pike, Forestville, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph_sician/ Atheroselevot disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, local groun modate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Exami ng physician and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: use yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown signed by ti Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Prabetes 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy page performed? 2 🗆 No 1 🗌 Yes Yes 2 No ector, 25. Was case referred to medical Be 26. Place of Death (Check only one) examine ? Hospital Other: မ 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred 1. Natural 5 Pending nours after death.

neral Director: A
filled in by the fu Accident Investigation М 2 🗌 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral D

completed filled i Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Registrar

only one)

Date filed (Month,

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3001

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

		Ple							All Copies Mental Hyg		gible.	
		For State Registrar		LE OI IVIA	aryland	-	tificate of L			leg. N2 0		32662
Physicia		Decedent's Name (First, Mid- Shirley	dle, Last) Ann			Eiker			2. Date of Dear October		Year	3. Time of Death 6:16 A M
Medic Examin		4a. Facility Name (if not institution 3022 Lander Road	on, give street an	d number)		222002		Location of Death			nty of Death	
Funeral Director		5. Social Security Number 212-58-7528	6. Sex 1	√7 E	(In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		Year) 1951	9. Birthp Coun Mary	place (State or Foreign try) Land
the Maryland a or 28a-f show be notified at	Funeral Director	Usual Residence of Decedent 10a. State 10b. Coun MD Fre 10e. Street and Number	ederick		10c. City, T	own or Loc effer				10g. Citizen c		0d. Inside City Limits 1 ☐ Yes 2 🔀 No
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	3022 Lander B 11. Marital Status 1 X Never Married 2 M 3 Wildowed 4 Divorce	12. Was Arm arried 1 If Ye	Decedent Ed d Forces? Yes 2 X 1 s, Give or Dates.	ver in U.S.	If	/as Decedent of Hi Yes, specify Cuba	n, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	14. R	d Stat ace - Americ lack, White, o ify: Whit	an Indian, etc.
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nd 2 should saith and N n 27 is ma er trauma		19a. Informant's Name/Relation Sherry Green		ter					fferson,	-		Code)
Page 1 ar ment of He ant: If iter ury or oth		20a. Method of Disposition 1 XBurial 2 ☐ Crematic 4 ☐ Donation 5 ☐ Other		from State	cem	etery, crem	sition (Name of atory or other place et Cemet		Date 8/2011	^{20c.} Locatio Freder	•	
permit. Depart Import any inj		21. Signature of Funeral Service	Licensee	M	101222				eney & B , Freder			
Physician/ Medical		23a. Part 1. Enter the disease, shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	t only one cause	on each line.			r the mode of dying	-	or respiratory arre	est,		Approximate Interval Between Onset and Death 5 mun 16 5
executed an and ial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of lining) that initiated events resulting in death) Last	b	e to (or as a	consequenc	ce of):						
(e) Fi (e)		resulting in death) Last	d		Consequent							
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	~ I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 4	s, outcome o Live Birth 2 Pregnant at Unknown	Fetal de		Ectopic pregnance Other (specify)	У			Date of delive	ery Day Year
requires that the de been signed by the should be detached	ed by P	Part II. Other significant condi	tions contributing		t not resultir	ng in the ur	derlying cause giv	ren in Part I.				ne cause of death?
The law req icate has bee ; page 2 shoi									24a. Was a autops perfori 1 🗆 Yes	ned?	o. Were autor prior to condeath?	osy findings available mpletion of cause of 2 No
ysician s certif director	To Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 ☐ No	Hospital:	1 ☐ Inpatier	nt 2 \square ER	/Outpatient	Othe	er:	ck only one) Iome 5 Reside		thar (Cnacify	1
Attending Phyrdeath.	Certificate: T	3 Suicide 6 Coul	ing 28a. tigation d not be	Date of injury Month, Day,	Year) 28	o. Time of injury	28c. Injury work	at	28d. Describe ho	w injury occu	urred	
ospital or hours afte ineral Dire d filled in t	<u> </u>	29a. Certifier 1 Certifyir	ng Physician: To	the best of m	(Specify)	je, death o	ocured at the time,	date and place, a	City or Town	se(s) and mar	nner as state	d.
To the Hc within 24 To the Fu completed		(Check 2 ☐ Medical only one) 3 ☐ Certifyir 29b. Signature and title of certifi	Examiner: On the g Nurse Praction of the grant of the gra	e basis of exa	amination and	d/or investig	gation, in my opinio eath occurred at the 29c. License	n, death occurred a time, date and pla number	at the time, date an ace, and due to the	d place, and o cause(s) and 9d. Date sign	due to the cau manner as sta ned (Month, I	use(s) and manner stated ated. Day, Yea <i>r</i>)
N		30. Name and address of person		cause of dea	ath (Item 23a	a) (Type, Pr	int)	791	Mark G.	60 - 0 !		

Registrar

31. Date filed (Month, Day, Year) 0CT 13 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State of Maryland / Dep	artment of Health and tificate of Death	001	1 32663				
			Registrar 1. Decedent's Name (First, Middle, Last)	uncate or Death	Reg. NZ U					
	Physicia Medio		Dorothy Anne Flanagan		Month September 27, 2	3. Time of Death				
~	Examin	er	4a. Facility Name (if not institution, give street and number) Rose Court at Riderwood Village	4b. City, Town, or Location of De Silver Spring	ath 4c. County of $P \cdot G$.	Death				
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) $1 \square M 2 \square F$ 89 Yrs.	if Under 1 Year If Under 24 H Months Days Hours Mi		Birthplace (State or Foreign Country) Ohio				
	d wo	l	Usual Residence of Decedent							
	ırylanı I-f sh ied a	cto	10a. State 10b. County 10c. City, Town or Lo			10d. Inside City Limits 1 ☐ Yes 2 🛣 No				
	he Ma or 28¢	Director	MD Howard Laur	10f. Zip Code	10g. Citizen of Wha					
	with the same same same same same same same sam	Funeral	9009 Melody Drive	20723	USA	t. Country :				
036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fur	1 Never Married 2 Married Armed Forces?	Vas Decedent of Hispanic Origin? Yes, specify Cuban, Mexican, Pue Yes 2 ³ No Specify:		American Indian, White, etc. 'hite				
2-0	Phour	plet	15. Decedent's Education 16a. Dece	ent's Usual Occupation	16b. Kind of Busin	ess Industry				
121	thin 72 ne. than the ne	(Specify only highest grade completed) College (1-4 or 5+) College (1-4 or 5+)								
0 0	ed wit Hygie other ent, th	Be C	17. Father's Name (First, Middle, Last)		ame (First, Middle, Maiden Surname)	nome				
/lan	d be fill Vental arked c	70	John F. McGarvey		Frances Yaeckli					
, Mar	id 2 shoul salth and I n 27 is m		19a. Informant's Name/Relationship (Type, Print) Patrick Flanagan/Son 19b. Maili 6917	g Address (Street and Number or I Persimmon Tree l	Rural Route Number, City or Town, State Road,Bethesda,MD	e, Zip Code) 20817				
Baltimore, Maryland 21215-0036	Page 1 an nent of He ant: If iten iry or oth				Date ept. 27 Alexandr:	·				
Balti	permit. Departn Importa any inju		21. Signature of Funeral Service Licensee	Name and Address of Facility 1n	s Funeral Home Ind vd. W., Silver Spi	2.				
			23a. Part 1. Enter the disease, or complications that caused the leath. Do not ent shock, or heart failure. List only one cause on each line.			Approximate Interval Between				
	nysician/	13	Immediate Cause (Final disease or condition Consestive Heart	ailure		Onset and Death unknown				
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P.O.	that the oned by the detacher	Physicia	g Unknown Part II. Other significant conditions contributing to death but not resulting in the u	adortving course given in Port I	Loo. Bittib					
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o d	law requires nas been sigr e 2 should be	plete				e autopsy findings available				
e Y	The ate h	Completed		-	performed? deat	r to completion of cause of th? Yes 2 \sum No				
ta	Physician: The this certificate al director, pag	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death (Ch	eck only one)	sted Living				
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ם כו	nding ath. r: After e fune	icate	1 Natural 5 □ Pending (Month, Day, Year) injury Accident Investigation	work? M 1 Yes 2 No	28d. Describe how injury occurred					
Division of Vital Records,	or Atte	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	et, factory, office	28f. Location (Street and Number of City or Town, State)	r Rural Route Number,				
5	spital hours a neral D		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	ccured at the time, date and place	and due to the cause(s) and manner as	s stated.				
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director, After this certific completed filled in by the funeral director,	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or inves only one) 3 Excertifying Nurse Practioner: To the best of my knowledge, (eath occurred at the time, date and p	lace, and due to the cause(s) and manne	r as stated.				
	P 3 5 6		29b. Signature and title of certifier 8.000 Qomma QO CRAP	29c. License number	29d. Date signed (M	SOL				
			30. Name and address of person who completed cause of death (Item 23a) (Type, F Eileen Gemmell, CRNP 3110 Grace	int)	er Spring, MD 2090)4				
	Stat	~	31. Date filed (Month, Day, Year)							
	Registra	r	SEP 28 2011 Lenter S. A.							

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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		For State Registrar		State o	f Marylar	•	irtment d tificate d			and M		gien Reg. N			000	C 1
		1. Decedent's Nam	e (First, Middle, La	ıst)							2. Date of De	ath	20	++	3. Time of D	eath
Physicia Medic		Judith		Ann		Faulk	ner				Month Septemb	er	^{ay} 28,	$2\overset{\text{Year}}{0}11$	4:42	P ^M
Examin		4a. Facility Name (if			iber)		4b. City, Tow	vn, or Loc	cation o				c. County			
		20329 Ke		2			Hage						Wash	ingt	on	
Funeral		5. Social Security N		Sex 1 □ M 2 X F	7. Age (In yrs. I		If Under 1 Y Months Da		Under 2 ours	24 Hrs. Min.	8. Date of Birl (Month, Da				thplace (State or F untry)	oreign
Director		234-62-40 Usual Residence of	J8Z		. 70	Yrs.					4/19/1				t Virgir	ia_
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	or	10a. State	10b. County		10c. Cit	y, Town or Loc	ation								10d. Inside City	Limits
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death item		11. Marital Status			dent Ever in U.		as Decedent Yes, specify (cify Yes or No-		14. Rac	ce - Ame	rican Indian,	
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the d	Physician/Medical	9 Unknown		9 ∐ Unkn	own											
s that gned		Part II. Other signifi			eath but not res	ulting in the ur	derlying caus	e given ir	n Part I.		\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		use cont	ribute to	the cause of dea	th?
quires quires sen siç	ted	De cop.	itus vic	273							1/2	Yes 2	! □ No	3 🗌 Pr	robably 4 🗆 Un	known
aw re as be 2 sh	Completed by	Hyper	tension		_						24a. Was autor		24b.	Were aut	topsy findings ava	ailable ise of
The I	် ပ	Emph	iscms.	+ CO PA							perfo	rmed?		death? 1 Yes	2 🗆 No	
cian; sertific ector,	Be	25. Was case referre examiner?	d to medical	Hospital:					of Death	(Check	only one)					
Physical this call direct	욘	1 ☐ Yes 2 ☐ 27. Manner of Death	No	1 ☐ I 28a. Date o	npatient 2	ER/Outpatient 28b. Time of	3 L DOA		☐ Nur		me 5 Resid				ify)	
ding th. After funer	Certificate:	Natural 2 Accident	5 Pending	(Monti	h, Day, Year)	injury	\ \	Injury at work? 1 Yes	2 🗀 1		28d. Describe h	iow inju	ry occurr	ed		
Atten rr dea: ector: by the	ŧ	3 Suicide 4 Homicide	Investigation 6 Could not be determined	28e. Place	of Injury - At ho				2 -	-	28f. Location (S	Street ar	nd Numb	er or Rur	al Route Number,	
tal or s afte al Dire		4 🗀 Mornicide	determined	buildin	g, etc. (Specify)					City or Tow	n, State	9)			
tospit thou unera	Medical	29a. Certifier 1 (Check 2	Certifying Phy Medical Exam	sician: To the be	est of my knowl	edge, death or	cured at the t	time, date	e and pl	lace, and	d due to the cau	use(s) a	nd mann	er as sta	ited.	or etated
To the Hospital or Attending Physician; The law requires that the death certificate be ew within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the buriar than the purious of the funeral director.	Me	only one) 3	Certifying Nur	se Practioner: T	o the best of my	/ knowledge, de	eath occurred a	at the time	e, date a	and place	e, and due to the	e cause	(s) and ma	anner as	stated.	o stateu.
5.¥ € 8		29b. Signature and t	0	mai	M. N			ense nun					1		, Day, Year)	
TF	-	30. Name and addre			of death //ta	23a) /Time P	int) \	1468	14.		Lin, m		7/2	7/ 2	LOU	
5		1	T - 7 A.		LEDER) 31°	701	riu	220	-10 W	ال				
State	е	31. Date filed (Month	Day, Year)	1	glstrar's Signat			• 2	•							
Registra	r	3	TO SEE SEE	and a Co	A COUNTY I	Ch. April										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		-	For State	State of Ma	arylan		artmen rtificate			Mental Hy		0011		0000
			Registrar 1. Decedent's Name (First, Middle, Last,				uncau	e or D	-catii	2. Date of De	Reg. N eath	2011	3	3 2 6 5 5 3. Time of Death
Physi Me	ician edica		BONNIE	S. FA	117	H				Month	2	S 20		0542 PM
Exa	mine	r	4a. Facility Name (If not institution, give s UNIVEVSITY of MW)		1 6114	2 (_	Town, or	Location of Deat	h Y	4	c. County of Dea	ath	
Fune	ral		Social Security Number 6. Sex	7. Age		ast birthday)	If Under	r 1 Year	If Under 24 Hrs.	8. Date of Bi	rth	9. Bi	rthplace	e (State or Foreign
Direct	tor		217–42–6685 1 L	M 2 X F	(57 Yrs.	Months	Days	Hours Min.	April D	8 / -	1944 Mar	yla	nd
and show		ė	10a. State 10b. County		10c. City	, Town or Lo	cation						10d.	Inside City Limits
Maryl 28a-f otifiec		<u>s</u>	MD Harford		Bel	Air								1 ☐ Yes 2 🛭 No
th the 3a or t be n	!	힐	10e. Street and Number				10f. Zip					Citizen of What C	ountry?	
erth wi erns 2 r mus		Funeral Director	1002 Bogart Circle	12. Was Decedent F	ver in U.S	13)		014 lent of His	panic Origin? (Sp	pecify Yes or No.	USA	14. Race - Am	ericen l	ndian
nd 21215-0036 filed within 72 hours after death with the Maryland al Hygiene. d other than "natural", or items 23a or 28a-f sho went, the Medical Examiner must be notified at		۾	1 Never Married 2 X Married	Armed Forces? 1 ☐ Yes 2 🔀 If Yes, Give			f Yes, spec 1 ☐ Yes	ify Cuban	, Mexican, Puert	o Rican, etc.)		Black, Whi		ndian,
-00;		eted	3 Widowed 4 Divorced	Year or Dates.		-							hit	
215 in 72 h e. nan "n Medi	Subjective and Number 10c. City, Town or Location 10c. City, Town or Location 10c. State 10c. Street and Number 10c. Street and Number or No- It Specify Cuban, Mexican, Puerto Rican, etc.) 1d. Race-Black, Specify: Speci									Kind of Business	Indust	ry		
d with dygien ther the	9	ou I-		5+	.,	Homen	maker					n Home		
Maryland 21215-0036 2 should be filed within 72 hours after th and Mental Hygiene. 27 is marked other than "natural", o traumatic event, the Medical Exam		9	 Father's Name (First, Middle, Last) William Raymond Sa 	nsom					18. Mother's Nar Ruby Lo		•	n Surname)		
Maryland 12 should be file 14 and Mental H 27 is marked o		ŀ	19a. Informant's Name/Relationship (Typ	e, <i>Print)</i>		19b. Mailir	ng Address	(Street ar	nd Number or Ru	rai Route Numbe	er, City o	or Town, State, Z	ip Code	=)
and 2 straight searth searth ther tra			Andrew D. Faith/Hu	sband		L			rcle, B	el Air,	MD	21014		
Baltimore, Dermit. Page 1 and Department of Hea mportant: If item any injury or other			20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	CE	lace of Dispo emetery, cren	natory or of	ther place	atory Se	Date		Location - City of 1 David		
Baltimore, N permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr	e.	İ	21. Signature of Funeral Service Licenses	, _	1 000	22	. Name and	d Address	of Facility Ne	wman Fur	hera	1 Homes		
n gge #	0	1	Dixun Juin						275, Gra			D 2153	6	
			23a Part 1 Enter the disease, or complishock or heart failure. List only one	cause on each line.			r the mode		, such as cardiac	or respiratory ar	rrest,		Inte	proximate erval Between set and Death
Physicia Medic	al	ĺ	disease or condition resulting in death)	Due to (or as a			roce					-		
Examin	•	.	Sequentially list conditions, b											
led nsit	Evaminer		if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a	. Consequ	ence otj.								
execul an and rial-tra	F	LYG	that initiated events cresulting in death) Last	Due to (or as a	conseque	ence of);								
rate be executed physician and sthe burial-transi	polical	מונים		·										
certifica ding p	M/S		IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome o								00d Data of da		
death of atter	Physician/M		in the past 12 months?	1 Live Birth 2 4 Pregnant at 9 Unknown			Ectopic p Other (spe					23d. Date of de Month	Day	Year
at the			9 Unknown Part II. Other significant conditions con		it not resu	Iting in the u	nderlying c	ause dive	n in Part I	OZa Dida		use contribute to	- Al	use of dooth?
Veryines that the death certificate be executed to require that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	3	5												y 4 Unknown
aw requires as been sig	Completed									24a. Was		24b. Were au	itopsy f	indings available
ding Physician: The law h. After this certificate has funeral director, page 2 ?	J.									auto perfo 1 🗆 Yes	ormed2	death?		
sician: certific	B. B.	1	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	spital:				Othor	e of Death (Chec					
g Physicer this heral di	P E		27. Manner of Death	28a. Date of injury	/ 2	R/Outpatien 28b. Time of		Bc. Injury a	4 U Nursing H	ome 5 Residence 128d. Describe 1		6 Other (Spec ry occurred	cify)	
tendin leath. or: Aft	Certificate		1 Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day,	rear)	injury	М	work?	es 2 🗆 No		·			
lor At after c Direct	S S		4 Homicide determined	28e. Place of Injur building, etc.	y - At hon (Specify)	ne, farm, stre	et, factory,	office		28f. Location (S City or Tow		nd Number or Ru e)	iral Rou	te Number,
To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as	Medical		29a. Certifier Certifying Physic (Check 2 Medical Examine	ian: To the best of mr: On the basis of exa	ny knowle	dge, death o	ccured at t	the time, d	late and place, a	nd due to the ca	use(s) a	nd manner as sta	ated.	\
o the Prithin 2, o the Formplet	Σ		only one) 3 Certifying Nurse	Practioner: To the b	est of my	knowledge, d	eath occurr	red at the t	ime, date and pla	ce, and due to th	e cause	(s) and manner as	stated.	
F S F ŏ			Daw.	10					24312	_		ate signed (Monta H 25		
	5		30. Name and address of person who con	npleted cause of dea			rint)							
	tate	3	Danelle Back 1. Date filed (Month, Day, Year)					uin	viore in	I UU	V 1			
Regis	trar		SEP 2 8 2011	32. Registrar	1.	AR								

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		ForState	State	of Marylar		artment of		and M	ental Hy	giene		
		Registrar 1. Decedent's Name (First, Middl)	, Last)		Cer	tificate of	Death	1		Reg. No		32666
Physicia: Medic		Gladys Annette							2. Date of De Septem		2 0 11	3. Time of Death 10:35 AM
Examin		4a. Facility Name (if not institution			ntor	4b. City, Town, o	or Location				nty of Death Freder	
Funeral		Glade Valley Nu 5. Social Security Number	6. Sex	7. Age (In yrs.		If Under 1 Year			8. Date of Birl			nplace (State or Foreign
Director		214-34-9894	1 □ M 21 ⊠ F	7-		Months Days			lay 28		Vir	ntry) ginia
nd how art	ř	Usual Residence of Decedent 10a. State 10b. County		10c Ci	ty, Town or Lo	ration						10d. Inside City Limits
ING 21215-0036 Filed within 72 hours after death with the Maryland Ital Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Director	Maryland Frede	rick		-	erick						1 Yes 2 X No
a or 2 be no		10e. Street and Number				10f. Zip Code				10g. Citizen	of What Cou	intry?
th with ms 23 must	Funeral	7092 Catalpa Ro				2170	3			United	d Stat	es
or iter		11. Marital Status1 ☐ Never Married 2 ☐ Mar	Armed F	edent Ever in U. orces? 2 🔀 No		Vas Decedent of F Yes, specify Cub	Hispanic Ori an, Mexicar	igin? (Spec n, Puerto R	ify Yes or No- ican, etc.)		Race - Ameri Black, White,	
21215-0036 within 72 hours after giene. er than "natural", o , the Medical Exam	Completed by	3 ☐ Widowed 4 🛣 Divorced	If Van Ci	ve	1	☐ Yes 2X No	Specify:	*		Spec	ify: Wh	ite
15-(plet		nt's Education est grade completed	()	(Give I	ent's Usual Occup aind of work done	during mos	t of working	g	16b. Kind of	Business Ir	ndustry
vithin liene.	S	Elementary/Seconday (0-12)	College (1-4 or 5+)		NOT use retired, Service		ovee		Federa	al Gov	vernment
filed v al Hyg d othe	Be	17. Father's Name (First, Middle,	_ast)	-					(First, Middle,			
Maryland 2 should be filed th and Mental Hy 27 is marked oth traumatic event	၉	John William E						-	G1adys			
		19a. Informant's Name/Relations Barbara Eader /				g Address (Street Barberry						Code)
Saltimore, bernit. Page 1 and Department of Hea Important: If item any injury or other		20a. Method of Disposition 1 🔀 Burial 2 🗌 Cremation		20b. In State	Place of Disportant Comments of Place of Disportant Place of Place	sition (Name of patory or other pla naven L Garden	ce)	Sept.	^{ate} 29,	20c. Locatio	-	
Baltimo	1	4 ☐ Donation 5 ☐ Other (\$ 21. Signature of Fu					_	201				Maryland
Balt permit. Departr Imports any inju		1] 9		ctin 1	Mount	ain Hw	y. Fre	ot Cod derick	ly P.A. c, MD 21701
		23a. Part 1. Enter the disease, of shock, or heart failure. List of Immediate Cause (Final	complications that only one cause on e	caused the deat ach line.	th. Do not ente	r the mode of dyir	ng, such as	cardiac or	respiratory arr	rest,		Approximate Interval Between
⊸ Physician/⊸ ∠ Medical	İ	disease or condition resulting in death)	a	nonia (or as a conseq	uence off:						-	Day's
Examiner		Sequentially list conditions,	b Dyspl	hagia S	yndrome							Years
ed	dical Examiner	in any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	Due to	or as a conseq	uence ot):							Years
rate be executed physician and the burial-transit	Exa	that initiated events resulting in death) Last	C	(or as a conseq		Beabe					$\neg \uparrow$	
ate be ohysicii	dica		d	 .								
oortifica ding p	Ž	F FEMALE: 23b. Was decedent pregnant	23c. If ves. ou	tcome of pregna	ancv							
death c	Physician/M	in the past 12 months? 1 Yes 2 🖾 No	1 ☐ Live 4 ☐ Preg	Birth 2 Teta nant at time of	aldeath 3 🗌	Ectopic pregnand Other (specify)	су			- 1	Date of deliv Month	Day Year
that the c	Ph Š	g ☐ Unknown Part II. Other significant condition	g □ Unk		ulting in the un	adayl day assas =:	one in Dord		T.,			
ords, P.O. BOX 08/	Completed by	Lumbar Spinal			sulling in the ur		veri in Part	I.				he cause of death?
The law requires ate has been signage 2 should b	plet	Pulmonary Embo	1i						24a. Was a		o. Were auto	psy findings available ompletion of cause of
stcian: The law scriftcate has be lirector, page 2 s									perfor	rmed?	death?	
sician certifi	ň	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:			Loui	lace of Deat	,				
g Phy g Phy er this	ie: To	27. Manner of Death	28a. Date	Inpatient 2 of injury	28b. Time of	28c, Injur	4 tx ∐Nu yat		e 5 Resid			/)
or Attendin fter death. irector: Aft n by the fur	lica 	1 XX Natural 5 ☐ Pendin 2 ☐ Accident Investig 3 ☐ Suicide 6 ☐ Could	gation	th, Day, Year)	injury	M 1 🗆	<br Yes 2 □	No				
al or Attending Physician: The Is after death. I Director: After this certificate he din by the funeral director, page	Certificate:	4 Homicide determ	28e. Place	of Injury - At hong, etc. (Specify	ome, farm, stre	et, factory, office		28	Bf. Location (S City or Tow		nber or Rura	l Route Number,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check	Physician: To the bax xaminer: On the bax Nurse Practioner:	sis of examination	n and/or investi	gation, in my opinie	on, death oc	ccurred at th	ne time, date ai	nd place, and	due to the ca	use(s) and manner stated.
To th Within To th COMP		29b. Signature and title of certifier		DOSC OF THE	,ougo, u	29c. Licens	e number	and place,		29d. Date sigr	ned (Month,	Day, Year)
		PAWK				D265	16			Septem	ber 2	7, 2011
6		Allen J. Gilson				int) enue, Fre	ederio	ck, M	D 21702	2		
		1. Date filed (Month, Day Year)										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 24 2011 Cecilia 20:10 M **Flanagan** Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital Montgomery Olney Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Months Hours Min. 093-10-9160 96 **Director** 1 M 2 X F Aug. 24 1915 New York Usual Residence of Decedent 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland items 23a or 28a-f sho her must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Derwood 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 19845 Meredith Drive 20855 United States "natural", or iten edical Examiner r 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 Married Yes 2 🛛 No Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 🗷 No Specify: Specify: White 3 X Widowed 4 Divorced Completed Year or Dates Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ed other than " Elementary/Secondary (0-12) College (1-4 or 5+) Own Home 12 Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental F 27 is marked o r traumatic eve မ Tobin Joseph Killeen Margaret 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health of item 27 in other tra Eileen M. Daleus / Daughter 19845 Meredith Drive, Derwood, Md. 20855 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or ot 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) 9/27/11 Alexandria, Virginia Metropolitan Crem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Muriel H. Barber Funeral Home 50 20882 Box 5038 Laytonsville, Md. 0. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine If any, leading to immediate cause. Enter Underlying Cause (Disease or injury to (ur as a consequence uf) the burial-transi To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as 1 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery signed by the atter in the past 12 months?
1 Yes 2 No Day Month Year 9 Unknown Unknowr 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 autopsy perform 1 Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No 1 🗆 Yes မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 \sum Yes 2 \sum No 5 Pending 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and itle of certifier 60999 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Philippr. Olney

Registrar DHMH 17 Rev 06-2011

State

Prince

M.D.

pula

18101

gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Frances Moore Gusack 6:08 AM 0 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Silver Spring Examiner 4c. County of Death Prince George's Renaissance Cardens at Riderwood Village 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 😾 F Days Hours Min. Nov.12, 1912 98 215-44-8115 New Jersey Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George's Silver Spring 1 Yes 2 No 10f. Zip Code Citizen of What Country?
United States Funeral 20904 3160 Gracefield Road, #1106 12. Was Decedent Ever in U.S. 11, Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 XNo Specify: Specify: 3 X Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Federal Bureau of Elementary/Seconday (0-12) College (1-4 or 5+) Supervisor Investigation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Howard Allen Edna Lore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number. City or Town, State. Zip Code) 13022 Bellevue Street Beltsville, Maryland 20705 Jean Kearney -daughter Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Fort Lincoln Cemetery 9/28/2011 Page 1 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Brentwood, Maryland 4 Donation 5 Other (Specify) 21. Sig ____ of Fu eral Servic L' nsee Bonard AvessBorgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 Infer the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, wheart failure. List only one cause on each line. shock. Immediate Cause (Final) Onset and Death Physician/ Arteriosclerotic Cardiovascular Disease disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown signed by t Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b Arteriosclerotic Cerebral Vascular Disease 1 ☐ Yes 2 ☐No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an cate has t page 2 s prior to completion of cause of death? autopsv performed? Yes 2 X No 1 ☐ Yes 2 XNo 25. Was case referred to medical æ 26. Place of Death (Check only one) 1 ☐ Yes 2 🗓 No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 1 X Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred iniury work?
1 Yes 2 No 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29c. License number IU 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eileen Gemmell, CRNP 3110 Gracefield Road Silver Spring, Maryland 20904

State

Registrar

31. Date filed (Month, Day, Year)

SEP 28 2011

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 32669 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 9 Mildred Marie HARPLE 3:30 PM Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Emeritus at Hagerstown Hagerstown Washington 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) g. Birthplace (State or Foreign 8. Date of Birth 1 🗆 M 2 🕱 F Days Months Min. eb. 5, 1 Hours **Director** 86 220-18-2002 Maryland Usual Residence of Decedent 28a-f show 10a. State 10b. County notified at 10c. City, Town or Location Director 10d. Inside City Limits Maryland Washington Hagerstown 1 Yes 2 X No ō 10e Street and Number 10f. Zip Code er than "natural", or items 23a on the Medical Examiner must be 10g. Citizen of What Country? Funeral 54 Harvard Road 21742 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Completed 3 Widowed 4 Divorced white 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 h and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) cook nursing home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Vernon L. Miller Irene Elizabeth unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra Linda Fields - daughter 9708 Fernwood Lane, Hagerstown, Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Page 1 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State Rose Hill Cemetery 10/4/11 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Dementia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury that initiated events Diabetes -transil ecurs mellituo and Due to (or as a consequence of resulting in death) Last burialattending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending above. Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Pregnant at time of death Month Vear Yes 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Demorks Completed 1 ☐ Yes 2. ☐ No 3 ☐ Probably 4 🖺 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performed? Yes 2 N 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 🗷 No Hospital Other: 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🗷 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident Suicide Investigation M 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29c. License number water momute, canp R128088 9/30/2011

State

TIN-5

qui

strar's Signature

Hagerstown.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRNP

Kate Smith

Date filed (Mont

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Patricia Ann Higman Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Washington County Hagerstown Social Security Number **Funeral** Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, 1 M 2 X F Days 217-32-5188 Mary Land 75 Hours **Director** Sep. 1935 Usual Residence of Decedent 28a-f show with the Maryland 10a State 10b County 10c. City, Town or Location notified at Director 10d. Inside City Limits Maryland Washington County Smithsburg 1 Yes 2 X No 10e. Street and Number ò 10f. Zip Code ms 23a or must be r 10g. Citizen of What Country? Funeral 11728 Mapleville Rd. 21783 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Infordant: If item 27 is marked other than "natural", or items amy injury or other traumatic event; the Medical Examiner mu once. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 Married 1 ☐ Yes 2 🏋 No If Yes, Give 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🏋 No Specify: Completed 3 X Widowed 4 □ Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Planing Mill Company CFOBe 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Frank E. Bushey Mary Hartle Bushev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Ann Higman-daughter P.O. Box 106 Cavetown, MD 21720 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Beaver Creek Cemetery 9-28-2011 | Beaver Creek, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Douglas A. Fiery Funeral Home auth 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ obc disease or condition 20 Shock Medical resulting in death) Due to (or s a consequence of **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury that initiated events Due to for as a concequence of, Examir attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Day Pregnant at time of death Month Year 1 Yes 2 No 9 Unknown the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by or Attending Physician: The law requires Kidney disease Inge wo Diaseles Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy certificate performed' death? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: |은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work' 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number September 25th, 2011 162588 Doous, M

State Registrar

JUL-10

Medical

Campus Road Hagestown 10 21742

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JUDITH READUA, RA
31. Date filed (Month, Day, Year)
SEP 88 2011

11116

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 6-For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September Velma Jean Henry 20 i Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death KegIONAL ICOMICA If Unde If Under 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days (Month, Day, Year) 219-28-8568 **Director** 1 - M 2 X F 78 11/21/1932 Pennsylvania Usual Residence of Decede 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Worcester Pocomoke City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1315 Princess Anne Lane 21851 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify. 3 X Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Raymond Grannas Anna Wilkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1903 Buck Harbor Rd., Pocomoke City, MD 21851 Frank Henry/Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Meadowridge Memorial Park Cemetery 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10/1/2011 Elkridge, MD Signature of Fun I Service Licensee Politoway Funeral Home Professional Association 107 Vine St., Pocomoke City, MD 21851 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ disease or condition Medical resulting in death) **Examiner** Sectiontially list condition Examiner if any, leading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last nding physician and use as the burial-tran Physician/Medical Division of Vital Records, P.O. Box 68760 use as t 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ☐ Live Birth 2 ☐ Fetal dea ☐ Pregnant at time of death for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the and do be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Whiknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an cate has perform this certificate 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 npatient 2 ER/Outpatient 3 DOA completely filled in by the funeral Manner of Death Date of injury Certificate: 28b. Time of 28c. Injury at (Month, Day, Year) 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A 1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check anature and 29c. License numbe 29d. Date signed (Month. Day, Year) 9/28 ame and address of person who completed cause of death (Item 23a) (Type, Print) A13 Carroll Street Salisbury mo 100 E hrun-Berg mueller State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State (Registrar	of Maryland /	-	rtment of F tificate of D		Mental Hyg	eg. N2 0 1	1 32672
	Physicia Medic		1. Decedent's Name (First, Middle, Last) Gary Ronald Hinebaugh					2. Date of Deat	:n	Year 9 49 pm
	Examin		4a. Facility Name (if not institution, give street and nur 9 Calderwood Road	mber)		4b. City, Town, or Deer		h	4c. County o	
	Funeral Director		5. Social Security Number 6. Sex 1 ★ M 2 ☐ F	7. Age (In yrs. last b	oirthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth	Year) 33	9. Birthplace (State or Foreign Country) MD
	rland F show d at	tor	Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Loca	ation				10d. Inside City Limits
	e Mary 28a-	Jirec	MD Garrett	Deer	r Par					1 🗶 Yes 2 □ No
	vith th	Funeral Director	10e. Street and Number 9 Calderwood Road			10f. Zip Code 2155	0	'	10g. Citizen of Wh USA	1
	e filed within 72 hours after death with the Maryland Ital Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		11. Marital Status 12. Was Dec	edent Ever in U.S. orces? 2 \square No	13. W	as Decedent of Hi Yes, specify Cuba	ispanic Origin? (S	pecify Yes or No- o Rican, etc.)	14. Race	- American Indian, , White, etc.
9036	urs afte tural", c al Exam	ted by	3 Widowed 4 □ Divorced If Yes, Gi Year or D		1	☐ Yes 2 🔀 No	Specify:		Specify:	White
215-	in 72 ho e. han "na Medic	Completed	15. Decedent's Education (Specify only highest grade completed Elementary/Seconday (0-12) College (*	f) 16	(Give ki	ent's Usual Occupa nd of work done of NOT use retired)		rking 🤫	16b. Kind of Bus	iness Industry
2	ed within Hygiene. other tha ent, the A	Be Co	12	,	S	ecurity			со	al
Maryland 21215-0036	should be file h and Mental F 7 is marked of traumatic ever	To B	17. Father's Name (First, Middle, Last) Charles E. Hinebaugh					me <i>(First, Middl</i> e, <i>N</i> ine Lick]	,	
Mary	1 and 2 should be if Health and Men item 27 is marke other traumatic	5	19a. Informant's Name/Relationship (Type, Print)	1.0		,		ral Route Number,		
	1 and 2 s f Health item 27 other tra		Jeffrey S. Hinebaugh-son 20a. Method of Disposition	20b. Place	of Dispos	ition (Name of		er Park,		Oity or Town, State
Baltimore,	Page 1 ment of ant; If it		1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	State Cumbe	etery, creme erland	atory or other place 1 Cremate	ory 9/3	0/2011		land, MD
Rall	permit. Page 1 and 2 si Department of Health a Important; If item 27 i any injury or other tra once.		21. Signature Juneral Service Licensee	k				vid A. Brand, MD 2		Guneral Home PA
			23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on experience of the complete of the complete of the complete of the complete of the complete of the complete of the comp	caused the death. Do ach line.						Approximate Interval Between
· .	Physician/ Medical	ì	Immediate Cause (Final disease or condition resulting in death)	(or as a consequence	e of):					Onset and Death
	Examiner	-E	Sequentially list conditions, b.							
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or impury	(or as a consequence	e of):					
_	certificate be executed adding physician and use as the burial-transit		that initiated events resulting in death) Last C. Due to	(or as a consequence	e of):					
2/60	ificate la ig phys as the l	Medical	IF FEMALE:		- 00					
BOX 68	death cert he attendir ed for use	Physician/M	23b. Was decedent pregnant in the past 12 months?	tcome of pregnancy Birth 2 Fetal deagnant at time of death		Ectopic pregnanc	ry		23d. Date	of delivery th Day Year
o O	t the de by the tached	Physi	g Unknown 9 Unk	nown						
S, T.	s the gnec	2	Part II. Other significant conditions contributing to c	death but not resulting	g in the un	derlying cause giv	en in Part I.	- 41		oute to the cause of death? B Probably 4 Unknown
Records,	law req nas bee	Completed						24a. Was ar	y pri	ere autopsy findings available ior to completion of cause of
E L	n: The ificate h		25. Was case referred to medical			OC DIA		perform		eath? Yes 2 No
NIT S	nysicia nis cert direct	To Be	examiner? 1 Yes 2 No Hospital:	Inpatient 2 ER/0	Outpatient	Othe	ace of Death (Che er: 4 Nursing F	dome 5 Reside	nce 6 🗆 Other	(Specify)
lo u	ding Pł th. Affer th funeral		Natural 3 - Ferfulling	of injury 28b ath, Day, Year)	Time of injury	28c. łnjury work M 1	at at	28d. Describe ho		
DIVISION	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 secondinates.	Certificate:	3 Suicide 6 Could not be	e of Injury - At home, ing, etc. (Specify)	farm, stree		100 2 2 110	28f. Location (Str City or Town		or Rural Route Number,
בֿ	ospital of hours a uneral D	Medical	29a. Certifier 1 Certifying Physician: To the b	pest of my knowledge	e, death oc	cured at the time,	date and place, a	and due to the caus	se(s) and manner	as stated.
;	the Hothin 24 the Fu	Med	(Check 2 Medical Examiner: On the base only one) 3 Certifying Nurse Practioner: 29b. Signature and title of certifier	sis of examination and To the best of my kno	d/or investig owledge, de	ath occurred at the	e time, date and pla	ace, and due to the	cause(s) and mani	
	F ≥ F 8		> Allan	reman	0	29c. License	1494	8 2	ou. Date signed (Month, Day, Year)
	MA	5	30. Name and address of person who completed cause	se of death (Item 23a)	(Type, Pri	nt)	,1th.	Server	00/1	(/ // //
E	Stat	_	31. Date filed (Month, Day, Year) 2011 32. 5	egistrar's Signature	1 6	all l	44	THE CEL	car	and, IND
	Registra	r	001 (J-4 2011 A	men p	1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 25 2011 Physician/ Harold Holbrook 11:33PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery 01nev 2719 Olney-Sandy Spring Road If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Numbe 8. Date of Birth (Month, Day, Year) **Funeral** 579-30-0623 Director 1 🔀 M 2 🗆 F 84 June 25 1927 Washington, DC Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 No 01ney Maryland Montgomery 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 20832 2719 Olney-Sandy Spring Road United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 72 hours after WWII 1 Yes 2 No Specify. White "natural", Completed 3 ☑ Widowed 4 ☐ Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Veterinary Clinic 12 Veterinarian Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Zella Pear1 Barnett should be William Addison Holbrook Lege 1 and 2 sh.
Legartment of Health and
Important: If item 27 is many injury or other. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2719 Olney-Sandy Spring Road, Olney, Md. 20832 Diana Covell/Granddaughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖾 Burial 2 🗌 Cremation 3 🗆 Removal from State 9/29/11 Adelphi, Maryland George Washington C. 4 Donation 5 Other (Specify) Name and Address of Facility Muriel H. Barber Funeral Home P. O. Box 5038, Laytonsville, Signature of Funeral Service Licensee 20882 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ month Cor Pulmonale disease or condition resulting in death) Medical Due to (or as a consequence of) Examine 10 years Chronic Recurrent Pulmonary Emboli Sequentially list conditions. Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last burialattending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) Pregnant at time of death been signed by the s should be detached 1 ☐ Yes 2 L 9 ☐ Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ I or Attending Physician: The law requires t after death. 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Atrial Fibrillation Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No 1 Yes 2 No certificate Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \(\text{Nursing Home} \) 5 \(\text{X} \) Residence \(6 \text{ \text{Other}} \) Other (Specify) 2 🛭 No 1 Inpatient 2 ER/Outpatient 3 DOA ည this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d Describe how injury occurred After injury 1 Matural 5 Pending WORK? 1 ☐ Yes 2 ☐ No Investigation within 24 hours after death To the Funeral Director: / Accident filled in by the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State

completely

2 L

Philip Herjum, M.D.

2011

(Check only one) 29b. Signature and title of certifier

31. Date filed (Month Pay

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Philip Herjum, M.D. 18109 Prince Philip Dr., #200, Olney, Md.

D 0035045

29c. License number

20832

September 26, 2011

29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

imend #20b & 20c per FH FCHD TM 9/27/11
State of Maryland / Department of Health and Mental Hygiene 32674 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 7:45 AM IRGINIA 01 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery 9029 Gue Road Damascus If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs, last birthday) 8. Date of Birth **Funeral** 1 □ M 2X F Months Davs Hours Dec. 16, 1930 Maryland 217-28-6156 80 **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location Director 1 🗆 Yes 2 No Damascus Maryland Montgomery 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ö Funeral 23a 9029 Gue Road 20872 U.S.A. items death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian 11 Marital Status Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. 5 9 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates "natural", Specify: White Completed 3 XWidowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other transmin. Own Home Homemaker Be 17. Father's Name (First Middle Last 18. Mother's Name (First, Middle, Maiden Surname) ည L. Green, Harvey Mary Virginia Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8800 Huntmaster Road, Gaithersburg, Maryland Doris A. Green - Niece 20c. Location - City or Town, State Hampstead, Maryland Gaithersburg, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, Wesley Grove Cemetery UMC Cometery 9/29/11 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Molesworth-Williams P.A., Funeral Home 21. Signature of Funeral Service Li 26401 Ridge Road, Damascus, Maryland 20872 Part 1. Efter the disease or complications that cause shock, or heart failure. List only one cause on each lin the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a, Part 1 Immediate Cause (Final Physician ymphoma disease or condition Medical resulting in death) Due to (o as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last that the death certificate be executed and Due to (or as a consequence of): inding physician use as the burial Physician/Medical Box 68760 IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ___ atter in the past 12 months?
1 Yes 2 X No Ď Month Year Day Pregnant at time of death signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No has page 2 certificate 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined To the Hospital Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29c. License number 29d. Date signed (Month. Day, Year) 7142 30. Name and address of person who completed cause of death 23a) (Type, Print) 3 riccard De. St 100, ROCKVILLE MD oleman

State

Registrar

32

egistrar's Sign

OR VS

31. Date filed (Month, Day, Year) SEP 3 0 2011

Zabiullah Ali, M.D.

30. Name and address of person who completed cause of death (Item 23a)

32. Registrar's Signature

State Registrar Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

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hirley A. Horch		1- For State	f Maryland /	•		of Dea		iu ivieiii	lai i iy		aa Na	2011	32678
Physici	an/	Registrar 1. Decedent's Name (First, Middle,Last)							2	. Date of Deat			3. Time of Death
Medical Exami	iner		ORCHLER							Month October 1	, 2011	Year	2017 hrs
		4a. Facility Name (if not institution, give s Union Hospital	street and number)			4b. City, Elkto		r Location o	of Death			County of Deat ecil	h
Funeral		Social Security Number 6. Sex	7. Age	(In yrs. la	st birthday		der 1 Yea	_		8. Date of Bir	th (MM/E	DD/YYYY) 9. Bir Forei	rthplace (State or
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' any		10a. State 10b. County		10c. City,	Town or L	ocation		_					10d. Inside City Limits
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WD 21215.0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho maric event, the Medical Examiner must be notified at once	Director	10e. Street and Number 209 NORTH MAIN STI	REET #6				ip Code 1921			10	0g. Citiz US	en of What Cou SA	ntry?
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r death or ite	Funeral	1 Never Married 2 Married	1 Yes 2	X No		If Yes, spec	_		Puerto Ri	can, etc.)		White, etc.	
s after	þ	3 Widowed 4 X Divorced If	r Dates:			Yes :							HITE
5-0036 led within 72 hours after Hygiene. other than "natural", the Medical Examiner	Completed	15. Decedent's Education (Specify only Elementary/Secondary (0-12)	College (1-4 or 5			edent's Usua g most of wo					16b, Ki	ind of Business/	Industry
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5-00 ed wil fygien other	2	17. Father's Name (First, Middle, Last)			11000	1111111				irst, Middle, N			MOTORING
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	æ	JAMES LLOYD								MOUSLE			
Baltimore, MD 21215 permit. Pages I and 2 should be file Department of Health and Mental H Important: If item 27 is marked of injury or other traumantic event, til	٩	19a. Informant's Name/Relationship (Typ JAMES LLOYD	e, Print)									y or Town, State DE 1981	
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Pages Pages sent of		4 Donation 5 Other Specify:	Removal from Stat	FAM	IILY SERV	r other place CREMAT	LION		OCT 2011	5,	 wii	LMINGTON	N. DE
Baltimore, permit. Pages I as Department of He. Important: If ite	ı	21. Signature of Funeral Service License	e ,	***		2. Name and	d Address	s of Facility		РО ВО			,
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ox 6 th cert ttendii	icia	past 12 months?	4 Pregnant at ti	me of deat		Other (Spe							,
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours a er death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn	Ď	Part II. Other significant conditions	entributing to death	but not res	uning in t	ie underlyin	g cause (given in Par	τι.				the cause of death? pably 4 Unknown
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Division To the Hospital or Attend within 24 hours a er deat. To the Funeral Director completely filled in by the t	Medical	one) 2 Medical Examiner: O	n the basis of exami										
F. P. E.	Me	29b. Signature and title of certifier	d manner stated.			29	c. Lic en s	e number			29d. Da	ate signed (Moi	nth, Day, Year)
		Allen Bron	mll. M	4)			O.C.	M.E.		_	Octol	ber 2, 2011	
	ŀ	30. Name and address of person who com	pleted cause of dea	•	•								
			stant Medical E				more S	treet, Ba	ıltimore,	MD 2122	3		
St Regist	_	31. Date filed (Month, Day, Year) OCT 1 3 2011	3. Registrar's	Signature	pa	Kal							

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Andrew Kundrat September 23. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death Silver Spring Holy Cross Hospital Montgomery Social Security Number If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 140-22-8987 **Director** 1 X M 2 🗆 F 83 12/15/1927 New Jersey 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director Silver Spring 1 Yes 2 X No Maruland Montgomery 10e. Street and Number 10q. Citizen of What Country? Funeral items 23a 12806 Broadmore Road 20904 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 🖾 Yes 2 🗌 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. "natural", or 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No 3 Widowed 4 Divorced WWII Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) than, Elementary/Secondary (0-12) College (1-4 or 5+) Patent Examiner U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Andrew Kundrat Frances Barlow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Kundrat - Spouse 12806 Broadmore Road, Silver Spring, Maryland 20904 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State nent of ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Lincoln Crematory 09/29/2011 | Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, any 2 11800 New Hampshire Ave., Silver Spring, MD 20904 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part 1. Enter the disease, o shock, or heart failure. List Approximate Immediate Cause (Final Physician/ Acute Myocardial Infarction disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 L g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires to within 24 hours after death.

To the Funeral Director: After this recompletely filled in beautiful or an analysis of the properties. 1 Yes 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 X No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 No ပ္ 1 Inpatient 2 X ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Tes 2 No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific D67355 September 23, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Daniel K. Sherk, M.D., 1500 Forest Glen Road, Silver Spring, Maryland 20902

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

SEP 28 2011

Box 68760

82. Registrar's Signature

11-07411 Marsha Kinzer Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 20 1 3 2 6 7 8

iarsha Kinzer		1- For State Registrar	ate of Maryla		artment o <i>rtificate o</i> i		i Menta	l Hygiene	Reg.	Z U	3 1	32010
Physici		 Decedent's Name (First, Midd. 	e,Last)		-			2. Date of	f Death			Time of Death
ledical Exam	iner	Harsha Gail Ki		<u> </u>				Octob	er 3, 2			1332 hrs
		4a. Facility Name (if not institution University Hospital	n, give street and nu	mber)		4b. City, Town, or L Baltimore	ocation of D	leath		4c. County of Baltin		City
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 2	4Hrs. 8. Date	of Birth(MM/DD/YYYY)		
Director		235-76-1259	1 M 2 X F		64 Yrs	Months Days	Hours	Min. Feb	.25,	1947	Countr	West ^{y)} Virginia
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215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	Completed	17. Father's Name (First, Middle,	Last)		Realt		3. Mother's N	ame (First, Mic		den Surname)	tate	Company
215 215 oe file ntal Hy ked o	Be (Louis A. Kaufm	an,Jr.				Marie			Carpe	er	
21 nould id Men	P	19a. Informant's Name/Relations	nip (Type, Print)		19b. Mailing	Address (Street	and Number	or Rural Rout	Numbe	r, City or Town,	State, Zip	Code)
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Baltimore, permit. Pages a Department of Her Important: If ite		20a. Method of Disposition 1 Burial 2 X Cremation	3 Removal fro	m State	Place of Dispos crematory or oth	ition (Name of ceme ner place)	etery,	Date	2	0c. Location - C	ity or Tov	vn, State
t. Pag tment trant:		4 Donation 5 Other Sp	ecity:/	Hac		Cremato)-08-20				Maryland
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygient Anneal Hydiental Hitem 71 is marked other than "natural", or items 23a, or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once		21. Ilignature of Funeral Section	Licentee		22. N	ame and Address of S.Conoc	of Facility O	sborne	Fune	eral Hor	ne,P.	A. MD 21795
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Box 6876 e death certificate the attending phy ed for use as the l	Physici	1 Yes 2 V No 9 Unk	10Wn 9 Unknow	nt at time of de	ath 5 Oth	er (Specify)			- 1			
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eco he law ate has	mo							_ _	erformer es 2	d? dea	ath? Yes	2 \(\backsquare \) No
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F 12 12 12 12 12 12 12 12 12 12 12 12 12	2	examiner? 1 ✓ Yes 2 No			ER/Outpatient			rsing Home			Other:	
~ .≥	Ë	27. Manner of Death 1 Natural 5 Pendi		f Injury Day,Year)	28b. Time of In					injury occurred inderwei		roial
Division tal or Attendiu rs after death. al Director: △	cati	2 X Accident Invest	igation Id 10		1200 h	t, factory, office buil	s 2 X No	proce	dure		-	Route Number, City
Divi	Certification:	3 Suicide 6 Could 4 Homicide	not be			lospital	iding, etc.	or To	wn, State)	OI RUIAI F	Route Number, City
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier (Check only 1 Certifying Ph	ysician: To the best niner:On the basis of	of my knowledg	ge, death occurr	ed at the time, date			cause(s)) and manner a		use(s)
To the within To the comple	Medical	2 Medical Exam 29b. Signature and title of certifier	and manner sta	ited.	or invostigati	29c. License r		od at the time,		d. Date signed		
	-	110		1.40	. \	O.C.M.		DOME		october 4, 2		_ =,, , , ,
	ł	30. Name and address of person v	vho completed cause	of death (Item	23a)							
		Theodore M. King, Jr.,		•		00 W. Baltímo	re Street	, Baltimore	MD 2	1223		
	77	31 Date filed (Month, Day Year)	22 8	istrar's Signatu		TVI.						

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep	partment of Health and N		
			Registrar 1. Decedent's Name (First, Middle, Last)	ertificate of Death	Reg. 1	No. 3. Time of Death
	Physicia Medic		Zhen Li		Septembe	PM 22, Year 2011 1132 PM
	Examin		4a. Facility Name (if not institution, give street and number) 21035 Sojourn Court	4b. City, Town, or Location of Death Germantown		4c. County of Death Montgomery
	Funeral Director		5. Social Security Number 6. Sex 1. Age (In yrs. last birthday, 1. ☐ M 2 🖾 F 5. Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth 10 26 / 195	9. Birthplace (State or Foreign China
<u> </u>	ryland I-f show ied at	ctor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L MD Montgomery Germanto			10d. Inside City Limits 1 Yes 2 □ No
)	th the Ma 3a or 28a t be notif	Funeral Director	10e. Street and Number	10f. Zip Code 20876		Citizen of What Country?
	r death wi		21035 Sojourn Court	. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian, Black, White, etc.
-0036	ours after atural", o cal Exam	eted by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.	1 Yes 2 No Specify:	166	Specify: Asian D. Kind of Business/Industry
1215	ithin 72 h ene. r than "na the Medi	Completed by	(Specify only highest grade completed) (Giv life. Elementary/Secondary (0-12) College (1-4 or 5+) 4 M	edical		
and 2	be filed w ental Hygi ked othe ic event,	To Be	17. Father's Name (First, Middle, Last) Li Yong Hua	18. Mother's Nam Cai Xiu	ne (First, Middle, Maid 1 Jie	len Surname)
Mary	27 is mar traumati		19a. Informant's Name/Relationship (Type, Print) 19b. Ma Victoria Qin — daughter 128	iling Address (Street and Number or Rur 10 Dogwood Hills I	al Route Number, City Lane Fairfa	y or Town, State, Zip Code) ax VA 22033
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any futury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1	ematory or other place)		c. Location - City or Town, State delphi, MD
Balti	permit. F Departm Importa any inju			Banzarandenssof Filitado 1170 Rockville	rg Memori	al Chapels Inc kville MD 20852
	A		23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line. Immediate Cause (Final		or respiratory arrest,	Approximate Interval Between Onset and Death
	Medical Examiner		Immediate Cause (Final disease or condition resulting in death) Breast a. Breast Due to (or as a consequence of):	Cancer		10 year
	y 1 0	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury	_		
	ate be executed hysician and the buriters	dical Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence of):			
200	icate b physi s the b		d			
Box 687	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriturens!	Physician/Me		Contract Con		23d. Date of delivery Month Day Year
s, P.O.	ires that the dea signed by the a Id be detached i	2	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobace	co use contribute to the cause of death?
Division of Vital Records, P.O.	he law require ite has been si bage 2 should	Completed			24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death? No 1 ☐ Yes 2 No
Ta F	cian: T ertifica ector, p	Be C	25. Was case referred to medical examiner? Hospital:	26. Place of Death (Che	ck only one)	
ι of Vi	ling Physi 1. After this o funeral dir	ate: To	1 Inpatient 2 ER/Outpat 27. Manner of Death 1 Natural 5 Pending P	of 28c. Injury at	28d. Describe how in	e 6 ☐ Other (Specify) injury occurred
ivisio	after death	Certificate:	2 LAccident Investigation 3 Suicide 4 Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)		28f. Location (Stree City or Town, S	at and Number or Rural Route Number, state)
	To the Hospital or Attending Physician: The law within 24 burus after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier (Check only one) 3 Certifying Physician: To the best of my knowledge, dear only one) 3 Certifying Nurse Practitioner: To the best of my knowled	restigation in my opinion, death occurred	at the time, date and p	place, and due to the cause(s) and manner stated.
	To the within To the COMP	2	29b. Signature and title of certifier M.D.	29c. License number > 0 0 6 3 8 2 8	29d.	Date signed (Month, Day, Year)
	V			e, Print) Cor Dr. Suite	435. Ro	ckville, MD 20850
	Sta Registr		31. Date filed (Month, Day, Year) SEP 28 2011 32/Registrar's Signature			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 1 - State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 09/21/2013 VIRGINIA WASHINGTON LAW 10:51 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 7931 Mandan Road, #201 Greenbelt Prince George's 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 F Days Hours Min. 6/11/22 **Director** Yrs 225-40-1084 89 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director notified 1 Yes 2 No MD Prince Georges Greenbelt ō 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? be items 23a Funeral U.S. 7931 Mandan Road, #201 20770 death v Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 X No If Yes, Give Year or Dates. ō þ 1 Never Married 2 Married 21215-0036 Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. 1 ☐ Yes 2 2 No Specify: "natural" Specify 3 Divorced 4 Divorced Completed Black er than "natur , the Medical ! 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) ⊥2th Food Service/ Univ of Md. Food Service ed other Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) alth and Mental H 27 is marked of er traumatic ever ည David Washington Virgie Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other to once. 7931 Mandan Rd., #201, Greenbelt, MD 20770 Joseph Theodore Law. Jr./spouse 20a. Method of Disposition 20b. Place of Disposition (Name of Cemetery, crematory or other place)
Md. Nat I Cemetery 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal fro 4 Dogation 5 Other (Specify) Mal. 9/29/2011 Laurel, MD 22. Name and Address of Facility Snowden Funeral Home 21. Signature of Funeral Service L 246 N. Washington St. Rockville, MD 20850 23a. Part 1. Enter the disease, or co shock, or heart failure. List only plications that caused the de one cause on each line. . Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Multi-infarct dementia disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** atrial fibriliation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or impur that initiated events resulting in death) Last nypertension Due to (or as a consequence of): attending physician for use as the buria Physician/Medical P.O. Box 68760 the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year the a 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Records, type 2 Diabeties, chronic obstructive, pulmonary disease 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Osteoarthritis, osteoporosis page 2 s autopsy performed?
☐ Yes 2 🔀 N 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State

Registrar

npleted

within 2 To the I

(Check

only one) 29b. Signature a

Thomas E.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32. Registrar's Sig

Maslen,

SEP 28 2011

DHMH 17 Rev 7/2009

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

7525 GreenwavCenter Drive, Greenbelt, MD 207/0

29d. Date signed (Month, Day, Year)

9/22/2011

29c. License number

DD55559

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arry Richard Le	ewis	1- For State	ate of Maryland		rtment of tificate of		Mental F	lygiene	Ogibio.	201	1 3268
Physicia Medical Exami		1. Decedent's Name (First, Midd						2. Date of D Month	eath Day	Year	3. Time of Death 1731 hrs
neuicai Exaiiii	ner	HARRY RIC 4a. Facility Name (if not institution		NIS	4	lb. City, Town, or L	ocation of Deat		21, 2011 4c. Co	unty of Deat	
		Long Point Farm Roa		/1 1		Oxford	True	In Date of	Talb		101
Funeral Director		5. Social Security Number 218-48-5828	6. Sex 7. A	ge (in yrs. ia	ast birthday) Yrs.	Months Days	If Under 24Hr Hours Min	<u> </u>	8,1947	Forei	rthplace (State or gn puntry) MARYLAN D
		Usual Residence of Decedent	123 W 2			<u> </u>		1101 2	,1747		
il in any		10a. State 10b. County MARYLAND			Town or Location STON	on					10d. Inside City Limits 1 Yes 2 No
th the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number	·		DION	10f. Zip Code			10g. Citizen	of What Cou	
h the M 3a or 2		5062 LONG P	OINT FARM DE	RIVE		2160	1		UNIT	ED_ST	ATES
ath wit items 2 ust be n	neral	11. Marital Status 1 Never Married 2 M	12. Was Deceder Armed Forces	?		s Decedent of Hisp es, specify Cuban,				Race - Amer White, etc.	ican Indian, Black,
after de	by Fun	3 Widowed 4 X Div	rorced If Yes, Give Year or Dates:	≅∐ № 965–69	1 🗆	Yes 2 X No	specify:		Spe	cify: WH	ITE
2 hours "natur		15. Decedent's Education (Spe Elementary/Secondary (0-12)	cify only highest grade co			's Usual Occupationst of working life.			16b. Kind	of Business/	Industry
5-0036 led within 72 hou Hygiene. other than "nat	Completed	12		0.7	SUP	ERVISOR			CO	NSTRU	CTION
D 21215-00; should be filed with and Mental Hygiene 7 is marked other thatic event, the Men	Be Co	17. Father's Name (First, Middle HARRY A.	LEWIS	•		11	8.Mother's Nam			name)	
2121; hould be fill and Mental F is marked	To B	19a. Informant's Name/Relations			19b. Mailing	Address (Street	MARY and Number or	DAV Rurai Route N		r Town, State	e, Zip Code)
e, MD 1 and 2 she Health and Fitem 27 is		CONNIE AYDEL(20a. Method of Disposition	OTTE (SISTER		36437	III B	RIDGES	RD., WI	LLARDS	MD :	21874 Town, State
Baltimore, MD 21215-0036 remit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once		1 Burial 2 X Cremation		tate c	rematory or oth	er place)				•	,
Baltimore permit. Pages 1 Department of E Important: If injury or other		4 Donation 5 Other Si 21. Signature of Funeral Service		FIR		TE CR. CT		29,201	I MILL	199	
		George m. Han		MOO 2						MILLS	BORO, DE
Physician /Medical		23a. Party. Enter the disease, or failure. List only one cause	on each line.		Do not enter th	e mode of dying, s	such as cardiac (or respiratory a	arrest, snock, (or neart	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Neck Inju Due to (or as a cons):						
	ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a cons	equence of):						
	Examiner	cause. Enter Underlying Cause (Unsease or injury that initiated events resulting in death) Last	c. Due to (or as a cons	sequence of):						
executed an and al - transit	E E		d.			0.1	20 10 1/	. 11			
~ o .g.g.	edical	X UNPENDED IF FEMALE:	AMENDED 23			er me,gyz	20 10-12	4-11 Sm		مرينامات عمر	
tox 68760, eath certificate be attending physici for use as the buri	an/N	23b. Was decedent pregnant in the past 12 months?	I I LIVE DITTI		2 Feta	al death 3	Ectopic pregn	ancy	Mor	ate of deliver oth	y Day Year
Box 68760 c death certificate the attending physical for use as the bu	Physician/Me	1 Yes 2 No 9 Uni	known 9 Unknown	t time of dea	ath 5 Oth	er (Specify)			1		
P.O. Es that the d	by Ph	Part II. Other significant conditi	ions contributing to dea	th but not re	sulting in the ur	nderlying cause giv	ven in Part I.				the cause of death?
— 8 .50 e								24a. Wa			topsy findings available
e law re e has be	Completed							aut	opsy form <u>ed</u> ?	prior to death?	completion of cause of
Division of Vital Records, tal or Attending Physician: The law requir is after death. al Director: After this certificate has been is led in by the funeral director, page 2 should led in by the funeral director, page 2 should led in by the funeral director, page 2 should led in by the funeral director, page 2 should led in by the funeral director, page 2 should led in by the funeral director, page 2 should led in by the funeral director, page 2 should led in by the funeral director, page 2 should led in by the funeral director, page 2 should led in by the funeral director, page 2 should led in by the funeral director, page 3 should led in by the funeral director.	ပ္ပ	25. Was case referred to medical	The second state of the second	-			of Death (Check	only one)	2 No	1 🗸 Y	es 2 No
f Vital Physician: er this certif		examiner? 1 ✓ Yes 2 No 27. Manner of Death			ER/Outpatient 28b. Time of In			ng Home 5	Residence	6 🗸 Othe	r: Scene
on of sading Phath.	흲	1 Natural 5 Pend		(ear)	fd 5:29	1 1 7	es 2 X No		t fell		well
ViSion Atta	Certification:	3 Suicide 6 Coul	d not be 28e. Place of li			, factory, office bui	ilding, etc.	28f. Location	(Street and N	lumber or Ru	ral Route Number, City Point Farm
hou hou		29a. Certifier	mined (Specify)		und in v			Rd.	0xford	,Md.	
Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A	Medical	(Direction of my	nysician: To the best of m miner:On the basis of exa and manner stated.	_							
FSFS	¥	29b. Signature and title of certifie				29c. License					nth, Day, Year)
	-	30. Name and address of person	who completed course of	leath /Item	23a)	O.C.M	I.E.		August	22, 2011	
		Donna M. Vincenti, MI	· ·	,		V. Baltimore S	Street, Baltir	more, MD 2	21223		
Sta Registi	3.00	31. Date filed (Month, Day, Year)	32. Registra	r's Signatur	e ha	W.					
DHMH 17 Rev 1/20	_	ULI AA	CVIII-	a pi	ORIGINAL						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 29-Day Month -2011 16:58PM Violet Virginia Lewis 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 0akland Garrett Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2X□ F Davs Hours Min Month Day Year 9 Oakland, MD 72 214-36-6718 Usual Residence of Decedent 10h Count 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 Yes 2 XNo Preston Corinth 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 26764 HC 65 Box 121 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 M Married Specify: White 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Clothing Store Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maxine Wilma Reckart Luther Joseph Alexander 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HC 65 Box 121, Corinth, WV 26764 Gilbert Lewis 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 09/30/2011 WVU Memorial Vault Morgantown, WV 4 Donation 5 Other (Specify) 22. Name and Address of Facility WVU Human Gift Registry 21. Signature of Funeral Service Licenses PO Box 9131, Morgantown, WV 26506 23a. Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MYOCARDIA disease or condition resulting in death) Due to (or as a consequence of) Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Dav Year Pregnant at time of death 2 No 1 Yes 2 L Unknown 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown OBSTRUCTIVE CHRONIC 1 🗌 Yes

Physician Medical Examiner Examine

and I-transit

physician a the burial-1

attending ph for use as the

the

signed by t d be detach

within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 to complete the filled of the funeral director.

the Hospital or Attending

Physician/Medical

Completed by

Be

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Certificate:

Medica

Physician; The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Physician/

Medical

GCMH

WV

Examiner

Funeral

Director

ms 23a or 28a-f show must be notified at

items 23a

"natural", or

than,

Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Mental Hygiene.

Medical

Director

Funeral

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Completed

Be

with the Maryland

within 72 hours after death

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy perform

24b. Were autopsy findings available prior to completion of cause of death? 2 🗌 No 1 Tyes

DIABETES 25. Was case referred to medical examiner? Hospital 2. No 1 Yes

MELLITUS 1 Inpatient 2 ER/Outpatient 3 IDOA

26. Place of Death (Check only one) 28c. Injury at

4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide 4 Homicide determined

29b. Signature and title of certific

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28f. Location (Street and Number or Rural Route Number, City or Town, State)

21550

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

311 N Fourth Street Oakland, MD

29c. License number

D27205

09/30/2011

29d. Date signed (Month, Day, Year)

Karl E. Schwalm, M.D. 31. Date filed (Month, Day, Year) State

Registrar

			Plea	se Type or										-	gible.		
		For State Registrar		State c	of Mar	yland		ırtmen <i>tificate</i>			and M	1ental Hy	giene Beg N	20		32683	
Physicia	an/	1. Decedent's Name (Fit Fakhruddin		*								2. Date of Dea	ath			3. Time of Death	7
Medic Sexamin	cal	4a. Facility Name (if not	institution,	give street and num	nber)	-1		4b. City,	Town, or	Location	of Death	Бересп		c. County	of Deat	h	7
Funeral		Shady Grove 5. Social Security Numb		6. Sex	7. Age (I	n yrs. las	t birthday)	If Under	1 Year	If Unde	r 24 Hrs.	8. Date of Birt	th		tgom	hplace (State or Foreign	-
Director		none Usual Residence of Dec		1 ∆ M 2 L F		86	Yrs.	Months	Days	Hours	Min.	June 10	,192	25	Som	alia	
aryland a-f sho fied at	ector	D 1 4 .	b. County			^{0c. City,} Kara	Town or Loc	ation								10d. Inside City Limits 1 ☐ Yes 2 🔀 No	
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.	<u>اچ</u>	11. Marital Status 1 Never Married 3 Widowed 4		12. Was Dece Armed Fo 1 ☐ Yes If Yes, Giv Year or Da	rces? 2 X No e			/as Decede Yes, speci				cify Yes or No- Rican, etc.)		Bla	ce - Amer ck, White : Whi		_
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To the Hospital or Attending Physician: The law requires that the death certificate be execun within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial the completed filled in by the funeral director.	Physician/Medical	IF FEMALE: 23b. Was decedent preg in the past 12 mont 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	ths?	23c. If yes, out 1 Live I 4 Pregr 9 Unkn	Birth 2 [nant at tir	☐ Fetal o	death 3 🗌	Ectopic p Other (spe		/					ate of del	ivery Day Year	
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Stat Registra		31. Date filed (Month, Da	y, Year)		egistrar's	Signatur	La	W									Ī

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U 1 - State Registra, AMEND#1perMD 9/28/11; BMW, MoC@ertificate of Death 1. Decedent's Name (First, Middle, Last) Jose Pedro Dominguez Menjivar 2. Date of Death 3. Time of Death Month 2011 1:05 AM Physician/ OKenber Medical or Location of Death 4c. County of Death Facility Name (if not institution, give street and number 4b City, Town Examiner Johns OSDITA Daltimore 9. Birthplace (State or Foreign E Pour Salvador If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Hours 91/20 9/ 10964 47 220-15-8208 Director ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Directo Gaithersburg MD Montgomery 1 Yes 2 No 10f. Zip Code 20877 10g. Citizen of What Country? 10e. Street and Numbe 8 Benji Court Funeral ed other than "natural", or items event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.)

ELSalvadoren

1 🖎 es 2 🗆 No Specify: 12. Was Decedent Ever in U.S 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. White etc. 1 Never Married 2 Married \$ Baltimore, Maryland 21215-0036 "natural", 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) filed within 72 al Hygiene. Management Elementary/Seconday (0-12) Auto Dealer College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) Gavino Menjivar 18. Mother's Name (First, Middle, Maiden Surname)
Catalina Dominguez should be file and Mental I 19a. Informant's Name/Relationship (*Type, Print*)
Domingo Menjivar/Brother 18938 Quail Valley Blvd. Gaithers (Street and Number or Rural Boute Number City.or Town, State, Zip Code), Md20879 permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 20b. Place of Disposition (Name of Santiago, Nonoalco, 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State General Cemetery 10/2/2011 LaPaz, El Salvador 4 Donatig 5 Cher (Specify) PINITE IN PARTICE, P.A. 21. Signatur uneral Service Li 9241 Columbia Blvd.Silver Spring,Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition Physician/ RESSIPATORY Medical resulting in death) Due to (or as a consequence of): Examiner SINGULVER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of Cause (Disease or iinjury that initiated events resulting in death) Last 27N the attending physician and the for use as the burial-rans 212 Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be e within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live Birth 2 - Fetal death Day Month Year in the past 12 months? 5 Other (specify) Pregnant at time of death 1 Yes 2 No signed by the a ld be detached f 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 1 Yes 2 No Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Be funeral director, Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ ✓☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Medical Certificate: 12 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident npleted filled in by the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29d. Date signed (Month, Day, Year) 29c, License number 29b. Signature and title of certifie Res-000 ptember 2, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 N. Wolfe 8+, Baltime m021287 14-CV 31. Date filed (Month, Day, Year) SEP 28 2011 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien) State RegistareND#10bperFH,9/30/11; EMW,McCo Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Deta of Daath 3. Time of Deeth Physician/ September 22. 2011 Laura Elizabeth McGrath 5:10 pm Medical 4a. Facility Nama (if not institution, giva streat and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hyattsville Prince George's 4016 Hamilton Street 5. Social Sacurity Number 7. Aga (In yrs. last birthday) If Under 24 Hrs. **Funeral** 8. Data of Birth 9. Birthpiece (Stata or Foreign Gountry Maryland 1 M 2 K F Months Days Hours Director 214-90-4578 46 Usual Residance of Dacedent 28a-f shov 10b. Count 10a, State 10c. City, Town or Location Director 10d. Inside City Limits Prince George's must be notified Hyattsville Maruland 1 Yes 2 X No 10e, Straet and Numbe 5 10f. Zip Coda 10g. Citizan of Whet Country? Funeral 23a within 72 hours after death with U.S.A. 4016 Hamilton Street 20781 12. Was Decedent Evar In U.S Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yes, spacify Cuban, Mexican, Puerto Rican, atc.) 11. Marital Status 14. Race - American Indian, Armed Forces? or i Š Bleck, White, etc. 1 Navar Marriad 2 X Marriad Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify Yas Giva "natural", 3 Wldowed 4 Divorcad Completed Specify: White event, the Medical 15. Decedent's Education 16a. Decadent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grada complated) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Vice President Community Housing 5+ Be 17. Father's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Majden Surneme) and Mental 2 Nancy M. Glaser Frank H. McGrath traumatic 19a. Informant's Nama/Relationship (Typa, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important. If item 27 is any injury or other trau 4016 Hamilton Street, Hyattsville, Maryland 20781 James Craver - Spouse 20a, Mathod of Disposition 20b. Place of Disposition (Nema of cemetery, crematory or other plece) 20c. Location - City or Town, Stata ☐ Buriel 2 Cramation 3 ☐ Ramoval from State 4 Donation 5 Othar (Spacify) Lincoln Crematory: 09/28/2011 Brentwood, Maryland ure of Funeral Service Sign 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter tha disease, or complications that caused tha daath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only ona causa on each line. Intarval Batwaer Immediate Cause (Final Onsat end Death Physician/ disease or condition rasulting in death) Metastatic Colon Cancer Medical Due to (or es a consaquence of) Examiner Sequantially list conditions, if any, laading to immadiate causa. Enter Undarlying Causa (Disease or iinjury Examiner Due to (or as a consequence of) that the death certificate be executed attending physician and for use as the bunia mission that initiated avants resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Liva Birth 2 Fetal death 23b. Was dacadent pregnant 23d. Data of delivary 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yas 2 X No Month Dav Vear Pregnant at time of death signed by the a 1 Yas 2 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23a. Did tobacco use contribute to the cause of death? þ 1 Tes 2 X No 3 Probably 4 Unknown as been signal 2 should b Completed 24b. Wara autopsy findings evallabla prior to complation of cause of death? 24a. Was an Hospital or Attending Physician: The law has autopsy certificate ha performed? Yes 2 X No 1 Tas 25. Was cesa raferred to medica Be 26. Place of Death (Check only one) examiner 1 Yes 2 🕅 No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 K Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Dey, Yaar) Certificate: 28b. Time of 28c. Injury at 28d. Describe how Injury occurred After X Natural 5 Pending within 24 hours after death.

To the Funeral Director. Af death. 2 Accidant
3 Suicida
4 Homicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) datarmined Medical Certifying Physician: To the best of my knowledge, death occured at the tima, date and place, end dua to the cause(s) and mannar es stated.

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to tha cause(s) end manner stated 29a. Cartifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and placa, and due to the cause(s) and mannar as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, data and placa, and due to the cause(s) and mannar as stated the 29b. Signature end titl 29d. Date signed (Month, Dey, Year) MD19655 September 26, 2011 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) John Marshall, M.D. 3800 Reservoir Road, NW, Washington, DC 20007 31. Date filed (Month, Day, Yeer) SEP 28 2011 State Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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	-	StateRegistrar					Cei	rtificate of	Death		teg. No.	32000
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 28, 2011 9:40 Glenola H. Miller AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Garrett Goodwill Mennonite Home Grantsville 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth g. Birthplace (State or Foreign **Funeral** (Month, Day, Yea an • 30, Days Hours Mary I and 1 □ M 2 🔀 F 1923 220-30-7942 Director Usual Residence of Decedent an "natural", or items 23a or 28a-f show Medical Examiner must be notified at filed within 72 hours after death with the Maryland al Hygiene. 4 then "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 K No MD Garrett Grantsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21536 USA 239 Hemlock Dr. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black White, etc. \$ 1 Never Married 2 Married Yes 2 No Yes, Give 1 ☐ Yes 2 🙀 No Specify. 3 X Widowed 4 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) the Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be file of Health and Mental F item 27 is marked o Anna Miller Harvey S. Yoder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21522 MD P.O. Box 18, 11077 Bittinger Rd., Bittinger, Idella Bender/Niece 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If it ò 1 Burial 2 Cremation 3 Removal from State injury Bittinger Menn. Cemetery Oct.2, 2011 Bittinger, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Newman Funeral Homes, P.A. 21. Signature of Funeral Service Licensee any) lusorale De Lyen P.O. Box 275, Grantsville, MD 21536 23a. Part 1. Effer he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or learn t failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition KESPIRATOR Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Preumonic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events ZHEIMER Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical law requires that the death certificate be IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 menths?
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3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Extifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

Box 68760 P.O. Records, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certifics completed filled in by the funeral director, to Division of Vital

Baltimore, Maryland 21215-0036

DHMH 17 Rev 7/2009

State Registrar

only one 29b. Signature a

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robin Bissell, 124 Miller St., Grantsville, MD

Registrar's Signatur

DO03423

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First Middle, Last) 2. Date of Death 3. Time of Death Physician/ to th Luther Paul McClintock 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WMHS Regional Medical Center Allegany Cumberland Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 T F Months Days Hours April Day 8 (1921 Marvland 220-28-9787 **Director** 90 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Garrett Accident 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 101 Town View Dr. USA 21520 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. <u>ک</u> 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: Completed 3 Widowed 4 Divorced White th and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry
Garrett County Roads (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Department Truck Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Elias McClintock Clara Ringer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Linda D. Tomblin-Step-Daughter 39 Keller Rd., Accident, MD 21520 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Addison Cemetery Sept. 27, 2011 Addison, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Newman Funeral Homes, P.A. 21. Signature of Fureral Service Licensee Note P.O. Box 275, Grantsville, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or bear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ASPIRATI disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of). Examin attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Day Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ AND CHRONIC SYSTOLIC 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred the Hospital or Attending (Month, Day, Year) To the Hospital or Attenumy within 24 hours after death.

To the Funeral Director: After completed filled in by the fur Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated nd title of certifier 29b. Signature 29c, License number

State Registrar DHMH 17 Rev 7/2009

68760

Box

P.O.

Records,

Division of Vital

timera

Robustiano Barrera, 200 Glenn St. Suite 302, Cumberland, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

SEP 28 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2141 teirc 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore University Maryland Medical Ctr If Under 1 Year If Under 2 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** (Month, Day, Year) 06–26–1940 Min. 1 🔀 M 2 🗆 F Rhode Island **Director** 71 036-26-0235 Usual Residence of Decedent show 10d, Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director ems 23a or 28a-f sh r must be notified a 1 XYes 2 No P.G. Md Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral Page 1 and 2 should be filed within 72 hours after death with 20735 U.S.A. 4537 Natahala Drive ral", or items? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces?

1 X Yes 2 No Black, White, etc 1 Never Married 2 X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 1967–1971 Year or Dates! Specify: Black "natural" 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) than Elementary/Seconday (0-12) College (1-4 or 5+) Dept. of Airforce General Supply Foreman 12th other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) of Health and Mental H If item 27 is marked of r other traumatic ever မ Monteiro Amelia Gomes Peter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Health a 4537 Natahala Drive, Clinton, Maryland 20735 Anne Monteiro - Wife 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1X Burial 2 \square Cremation 3 \square Removal from State ō Department or Important: If any injury or Md Veterans Cemetery | 10-5-2011 Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) f Funeral Service Lice 22. Name and Address of Facility Ronald Taylor II Funeral Home Middleport Lane, White Plains, Maryland complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Enter the disease, o shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ Myocardial disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, reading to infinediate cause. Enter Underlying Exami ear Stage attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) 11 years Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death led by the a 9 Unknown After this certificate has been signed by funeral director, page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No hyothyroidism 1 Yes 25. Was e referred to / edica the funeral director, 26. Place of Death (Check only one) Be examiner? Hospital Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) r of Death 28c. Injury at 1 Natural Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation after death Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of 101386 201 person who completed cause of death (Item 23a) (Type, Print)

Greene St Baltamon 10+

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day

Baltimore

11-07467 Dennis Martz Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ennis Martz			ate of N	/laryla		•				Ment	al Hy	giene		20		32691
		1- For State Registrar				Certif	icate of	Deat	th				Reg. No.			
Physiciar Iedical Examin		1. Decedent's Name (First, Midd Dennis W	•	Mar								2. Date of De Month October	Day 5, 201			3. Time of Death 1436 hrs
		4a. Facility Name (if not institution Potomac River	n, give stree	et and nu	mber)		ľ		Town, or L psburg	ocation of	Death			. County of Vashingt		
Funeral		Social Security Number	6. Sex		7. Age (In y	rs last	hirthday)		er 1 Year	If Under	24Hrs.	8. Date of B				nplace (State or
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Aaryland 28a-f show	Director	10e. Street and Number						10f. Zi	Code				10g. Citi	zen of Wha	t Coun	try?
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Baltimo	1	21. Signature of Fundral Service	Licensee						Broad	-		ove-Bo ynesbo			une: 1720	ral Home,Ir
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To with	Ē	29b. Signature and title of certifie		manner st	iaioù.			29	c. License	number			29d.	Date signed	(Mon	th, Day, Year)
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d ,	+	30. Name and address of person					-					0.1055				
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OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. Z Certificate of Death Decedent's Name (First Middle Last) 2. Date of Death September 19, Physician/ 3:20 PM Betty Jo Owen 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 15008 Puffin Court Bowie Prince George's 8. Date of Birth (Month, Day, Ye July 14, If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Days Min Hours 1 M 2 X F Director 1929 Lamesa, Texas 525-54-8305 82 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items ?? - - any injury or other traumatic event. the Natural once. 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Director 1 X Yes 2 No MD Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 15008 Puffin Court 20721 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Force 1 Never Married 2 X Married þ Yes 2 🔯 No 1 ☐ Yes 2 X No Specify: If Yes, Give White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) life DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Maggie Cox Sebe J. Flowers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15008 Puffin Court, Bowie, MD 20721 Robert L. Owen / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🕅 Burial 2 🗌 Cremation 3 🗀 Removal from State cemetery, crematory or other place) 9/23/2011 Davidsonville, Maryland 4 Donation 5 Other (Specify) Lakemont Cemetery 4739 Baltimore Avenue 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Multiple Myeloma Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or illilury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No Dav Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 2 No 1 Yes 2 No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes 2 🔀 No 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27, Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 🗌 Yes 2 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 🖾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge death secured at the time date and place and dire to the

within 2 To the I

State Registrar

29b. Signature and title

SEP 3 0 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D53517

26,2011

			For State Registrar	State of M	aryland		artment <i>tificate</i>			and M	lental Hy	giene Reg. No. 2	011	320	692
and a	Physicia Medic	al	1. Decedent's Name (First, Middle, I Helen P. Pete	rs			4 00 T			t Dooth	2. Date of De Sept.	23, ^{Day} 201		3. Time/of	PM PM
)	Examin		4a. Facility Name (if not institution, g Holy Cross Ho 5. Social Security Number	spital	e (În yrs. last	t birthday)	4b. City, To Silve If Under 1	er S		3	8. Date of Bir	Mont	nty of Death Some 1 9. Birth		r Foreign
	Director		239-48-4835 Usual Residence of Decedent	1 □ M 2 X F	96	Yrs.	Months	Days	Hours	Min.	Aug •	1, Year 1915	Rasie	igh, N	
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Baltimore, I	oermit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other once.		Joyce P. Banks 20a. Method of Disposition 1 🕱 Burial 2 🗆 Cremation 3 4 🗀 Donation 5 🗀 Other (Sp	☐ Removal from State	20b. Pla	ce of Dispo	osition (Name natory or oth Ceme to	e of ner place	e)		Date	er Spr 20c. Location Rockv	n - City or T	own, State	4
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90	te be executed nysician and ne burial	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	b. Stage Due to (or as c. Due to (or as d.	a consequer	nce of):	ressu	re u	orcer					month	-
. Box 6876	To the Hospital or Attending Physician: The law requires that the death certificate L within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physical properties of the funeral director, page 2 should be detached for use as the tental properties of the funeral director.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No g ☐ Unknown	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a g ☐ Unknown	2 Fetal of	death 3	Ectopic pr Other (spe		4				Date of delive		/ear
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on of V	nding Phys ath. : After this e funeral dir	icate: To	1 Yes 2 X No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investige	28a. Date of inju (Month, Da		R/Outpatie 8b. Time of injury		c. Injury work?	4 ⊔ Nu at			dence 6 🗆 0		(y)	
Division	ial or Attendii s after death. al Director: Af ed in by the fu	Certificate:	3 Suicide 6 Could no 4 Homicide determin	ot be 28e. Place of Inj	ury - At hom c. (Specify)	ie, farm, str	eet, factory,	office			28f, Location City or To	Street and Nur wn, State)	mber or Rura	al Route Numb	per,
_	To the Hospital or A within 24 hours after To the Funeral Direction of	Medical	(Check 2 Medical Ex	Physician: To the best of aminer: On the basis of aminer: To the basis of the basis	examination a	and/or inves	tigation, in m	y opinio	n, death o	ccurred at	the time, date	and place, and	due to the c	ause(s) and ma	nner stated
	within 2		29b. Signature and title of certifier	uganich.	Rsm	MI		License	number 485			29d. Date sig 09/2		Day, Year)	
			30. Name and address of person w Barbara Supanich	no completed cause of o	death (Item 2	(3a) (Type, I	Print)	en R	Road,	Sil	ver Spi	ing, M	arylaı	nd 2091	.0
	Sta Registra		31. Date filed (Month, Day, Year) SEP 28 20	32. Registr	rar's Sig latur	per	e)								

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Paul David Pende		1- For State	State of Ma	aryland i		rtment of	Health and	Mental		-g	201	1	3269
Physician	n/	Registrar 1. Decedent's Name (First, Mi	idle,Last)			incate of	Dodin		2. Date of De				ne of Death
Medical Examin		PAUL DAVID PEN							Month Septemi				'14 hrs
		 Facility Name (if not instituted) 15107 Seneca Road 		and number)		1	4b. City, Town, or I Germantown		ath	100	County of De ontgomery		
Funeral		5. Social Security Number	6. Sex	7. Age	e (In yrs. la	st birthday)	If Under 1 Year			Birth (MM/D	D/YYYY) 9. I		(State or
Director		220-90-4827	1 M 2	F	49	Yrs	Months Days	Hours N	^{fin.} 8/1.1	/1962	2	eign Country)	_ Japan
kus	-	Usual Residence of Decedent 10a. State 10b. Count	у		10c. City, 7	Town or Locati	on					10d. l	Inside City Limits
È ,,	اة	MD Monto	omery		Germa	antown						1 🛚	Yes 2 No
ne Maryland or 28a-f show	Director	10e. Street and Number	-				10f. Zip Code			10g. Citize	en of What Co	ountry?	
ith the	ᇛ	15107 Seneca F		as Decedent	Ever in LLS	2 112 14/0	208/4 s Decedent of Hisp	ania Ori-in3 (Cif-V	U.S.			dian Diant
leath with the ritems 23a	Funeral		Married Arr	ned Forces?	X No		es, specify Cuban,	Mexican, Pue	rto Rican, etc.)	40- 1	Race - Am White, etc.		ыап, віаск,
ral", or	g L		ivorced If Yes, Gi	ve Year			Yes 2K No			s	Specify: V	Vnite	<u> </u>
2 hours	ğ	15. Decedent's Education (Special Elementary/Secondary (0-1:		st grade com ege (1–4 or 5			t's Usual Dccupationst of working life.			16b. Ki	nd of Busines	s/Industry	/
036 rithin 7 ene.	Completed	12th		-9- (*		Contra	ctor			Hon	ne Remo	xdelı	.ng
		17. Father's Name (First, Midd	e, Last)				1		me (First, Middle	•	urname)		
212 ould be Menta marke		Thomas Pender 19a. Informant's Name/Relatio	nship (Type, Prin	t)	_	19b. Mailing	Address (Street		a Thomps or Rural Route No		or Town, Sta	ite, Zip C	ode)
MD dd 2 shoulth and lith and m 27 is	Ĺ	Barbara Thomps 20a. Method of Disposition	on McEw	an/mot	her		Seneca R		ermantow				
Ore, eslan of Hea If ite	1	20a. Method of Disposition 1 Burial 2 Cremati				lace of Dispos ematory or oth	tion (Name of cem er place)	etery,	Date	20c. Lo	ocation - City	or Town,	State
it. Pag rtment rtment rtant: y or of	-	4 Donation 5 Other		//_	Arde	nt/Cre	matory ame and Address	9/	/27/2011	Har	nover,	MD	
Baltin permit. P Departme Importan injury or		21. Signaturo or Pulleral Service	K /	, un	de	246			nowden f n St., F				J85U
Physician /Modical	T	23a. Part I. Enter the disease, failure. List only one caus	or complications se on each line.	that caused t	the death. I	Do ot enter th	e mode of dying, s	such as cardiad	or respiratory a	rrest, shoc	k, or heart	Appr	roximate Interval ween Onset and
Examiner		Immediate Cause (Final diseasor condition resulting in death)		t Shotgur		to Chest						1	Death
	-1	Sequentially list conditions,	b	as a conse	Delice of).								
		if any, leading to immediate cause. Enter Underlying Caus	e	r as a conse	quence of):								
led Carried	Xan	(Disease or injury that initiated events resulting in death) Las	-	r as a conse	quence or):	v v						+-	
ng ga 7		UNPENDED	d	DED.								+	
760, cate be excephysician physician he burial		F FEMALE:	23c. If	yes, outcom	e of pregna	ancy		-		23d.	Date of delive	эгу	
Box 68760 death certificate be attending physical of or use as the bu	Clan	3b. Was decedent pregnant in past 12 months?	, L	Live birth Pregnant at t	ime of deat	*h ~ 🗔	al death 3	Ectopic preg	nancy	N	Month	Day	Year
the death certificate the death certificate by the attending phyched for use as the Driveinian			nknown 9 🗍	Unknown		3 🗀 Ott	er (Specify)						
of Vital Records, P.O. B og Physician: The law requires that the de ufter this certificate has been signed by the meral director, page 2 should be detached for To Re Completed by Dhy		Part II. Other significant cond	itions contribut	ting to death	but not res	sulting in the u	nderlying cause giv	ven in Part I.	23e. Did		se contribute t		se of death?
ds, equires een sig	erec.								- 24a. Wa				ndings available
Records, The law requires froate has been sig										ormed?	prior to death?	completi	ion of cause of
Vital Records, ysician: The law requirents in sertificate has been idirector, page 2 should the Recompletes.		25. Was case referred to medic	ai				26.Place	of Death (Chec	1 ✓ Yes k only one)	2 No	1 🗸	res	2 No
Physici r this corrupts of all direc	2	examiner? 1 ✓ Yes 2 No	Hospital: 1			ER/Outpatient			sing Home 5			er: Scene	
on of ading Phyth.: After the funeral		27. Manner of Death 1 Natural 5 Per	nding FO	Date of Injury Month, Day,Ye UND:	y 2 ar) I	28b, Time of In FOUND:	· · I _ · ·	at Work? es 2 ✔ No	28d. Describe Subject sh		occurred		
Division tal or Attendir rs after death. al Director: A led in by the fu	<u> </u>	2 Accident Inv	estigation Sep	22, 2011 Place of Inju		1645 hrs ne, farm, stree	t, factory, office bu		28f. Location	(Street and	Number or F	≀ural Rou	te Number, City
Division o spital or Attending tours after death. neral Director: Aft filled in by the fune		4 Homicide det	anneise a st	ecify) Res	idence				or Town, 15107 Sene	State) ca Road,	Germantow	n, MD	
Division of Vital Records, P.O. Box 6876(To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the b	בונים מונים		aminer: On the b				ed at the time, date on, in my opinion,						e(s)
مَ الْمُ	Ĕ Z	9b. Signature and title of certif		1/200			29c. License				ate signed (M		v, Year)
		aguns	rasself	1196	-AL 216	22-1	O.C.M	I.E.		Septe	ember 23,	2011	
		Melissa Brassell, MD	Assistant	: Medical I	Examine	er 900 W.	Baltimore Str	reet, Baltim	ore, MD 212	23			
Stat Registra	e ³ ar	SEP 28	2011	Registrar	s Signature	bare							
DHMH 17 Rev 1/2001		OCME	70			ORIGINAL							-

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 8 per fh g920 10-19-11 vt State of Maryland / Department of Health and Mental Hygiene []

			State of Maryland / Dep	artment of Health and M rtificate of Death		11 32694
	Physicia	n/	1. Decedent's Name (First, Middle, Last) Charles Richard Phetteplace	imodeo or Beatri	2. Date of Death Month September 25,2	3. Time of Death
and a	Medic Examin		4a. Facility Name (if not institution, give street and number) 2007 Day Road	4b. City, Town, or Location of Death Hagerstown	4c. County	
Art	Funeral Director		5. Social Security Number 215−36−6287	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth 1940 (Month, Day, Year) 2040	9. Birthplace (State or Foreign Country) Maryland
	yland f show ed at	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo		220, 27, 2010	10d. Inside City Limits
	the Man t or 28a- se notifie	Funeral Director	Maryland Washington Hagerst 10e. Street and Number	10f. Zip Code	10g. Citizen of V	1 ☐ Yes 2XXNo What Country?
	eath with ems 23a r must b	unera	2007 Day Road 11. Marital Status 12. Was Decedent Ever in U.S. 13.	21740 Was Decedent of Hispanic Origin? (Spec	U.S.A	e - American Indian,
9800	urs after de ural", or it Il Examine	by	1 Never Married 2 Married Armed Forces?	If Yes, specify Cuban, Mexican, Puerto F 1 ☐ Yes 2 ▼ No Specify:		k, White, etc.
1215-(thin 72 hoi ne. than "nat ne Medica	Completed	(Specify only highest grade completed) (Give Elementary/Seconday (0-12) College (1-4 or 5+)	dent's Usual Occupation kind of work done during most of workir IO NOT use retired) ner and operator	ng	usiness Industry penter
Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	To Be C	17. Father's Name (First, Middle, Last) David S. Phetteplace	18. Mother's Name	(First, Middle, Maiden Surname Grossnickle	
	and 2 should Health and Mi tem 27 is mar ther traumati		II II II II II II II II II II II II II	ng Address (Street and Number or Rural Day Road, Hagerst		State, Zip Code)
Baltimore,	Page 1 and ment of Her ant: If item ury or othe			matory or other place) Septe	mhor	City or Town, State
Balt	permit. Page 1 Department of Important: If i any injury or once.		Cott Munu 4	15 East Wilson Blv		
~	Physician/ Medical Examiner	_		er the mode of dying, such as cardiac or one of arrest slive large days		Approximate Interval Between Onset and Death
09	be e	dical Examiner	if any, leading to infinediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):			
20x 68/	death certific	Š	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	☐ Ectopic pregnancy ☐ Other (specify)	23d. Dat	te of delivery nth Day Year
ds, P.O.	juires that in signed build be deta	2	Part II. Other significant conditions contributing to death but not resulting in the t	ınderlying cause given in Part I.		ribute to the cause of death? 3 Probably 4 Unknown
DIVISION OF VITAL RECORDS,	n: The law requires that the fifcate has been signed by ti or, page 2 should be detach	Sompleted •	25. Was case referred to medical	OC Please of Death (Observe	autopsy performed? c	Were autopsy findings available prior to completion of cause of death?
т Уіта	Physicia this cert al direct	PD B	examiner? 1 ☐ Yes 2 🙀 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien		ne 5 Residence 6 🗆 Othe	
o uo	eath. or; After the funer	Certificate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	28c. Injury at work? M 1 □ Yes 2 □ No	8d. Déscribe how injury occurre	ed
DIVIS	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director, After this certific completed filled in by the funeral director,		4 ☐ Homicide determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)		28f. Location (Street and Number City or Town, State)	
)	the Hosp nin 24 hou the Fune apleted fi	Medical	29a. Certifier (Check (Check only one) 3 Certifying Physician: To the best of my knowledge, death only one) 3 Certifying Nurse Practioner: To the best of my knowledge,	tigation, in my opinion, death occurred at	the time, date and place, and due	e to the cause(s) and manner stated.
	viti To		29b. Signature and title of certifier	29c. License number D 6 5 3 4 4	29d. Date signed	d (Month, Day, Year)
K	1-10+1		30. Name and address of person who completed cause of death (Item 23a) (Type, IKATARAM MANJULA 11010	PACCT Hoges	• ;	1742
	Stat	е	31. Date filed (Month, Day, Year) 32. legistrar's Signature	A D		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIEM# 17perFH, G920, 1071972011, WS
State of Maryland 7 Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 23, Physician/ 2011 9:25 P M Emma J.Pearman Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Manor Care of Silver Spring Silver Spring Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country)Alabama 1 🗆 M 2 🖾 F Months Days Hours Dec. 18, Year) 926 Yrs Director 84 420-30-1395 Usual Residence of Decedent or 28a-f shov 10d. Inside City Limits 10a. State 10b. County within 72 hours after death with the Maryland rral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location Director 1 X Yes 2 No DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20019 4215 Gault Place NE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Year or Dates Specify: "natural", Completed 3 → Widowed 4 □ Divorced other traumatic event, the Medical 15. Decedent's Education 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Department of al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Navy Computer Specialist 12th permit. Page 1 and 2 should be filed Department of Health and Mental Hyr Important: If item 27 is marked othe any injury or other traumair. Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Luke O'Neal Jr. မ Elvira Mahone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20019 3229 Massachusetts Avenue SE Washington, DC Luke O'Neal Jr. - Brother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State October 1, cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Washington, DC Mt. Olivet 2011 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home, Inc. 20019 Washington, DC 4001 Benning Road NE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ Respiratory Arrest disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Lung Cancer Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immediate cause. Linter Underlying Cause (Disease or linjury sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Chronic Obstructive Lung Disease that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician hed for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Day Year Month 4 ☐ Pregnant at time of death 9 ☐ Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? After this certificate 1 Yes 2 No Yes 2 within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 No 욘 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 XNursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 🗌 No Accident Suicide Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Pactioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier License number Date signed (Month, Day, Year) 60 mpleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who 20878 Gaithersburg, MD Suite 202 -10810 Darnestown Rd. M.D.Raman Tuli,

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year) SEP 3 0 2011 32. Registra s Signatur

11-07341 Mitchell Pike Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

-	1- For State Registrar	o or waryland / L	Certificate of	Death	Reg.	ZU11	32696
Physician/ Medical Examine	Decedent's Name (First, Middle,L.)	ast) ndon Pik			2. Date of Death		3. Time of Death
wedical Examine	4a. Facility Name (if not institution, g			b. City, Town, or Location of De	Month September	30, 2011 4c. County of Death	1151 hrs
	St. Joseph's Hospital	,		Towson		Baltimore Cou	
Funeral Director	241-08-8537		yrs. last birthday) O Yrs.	Months Days Hours !	Min. Feb. 14	(MM/DD/YYYY) 9. Bir Foreig 1961 Co	thplace (State or in untry) PA
any	Usual Residence of Decedent 10a. State 10b. County	100	. City, Town or Location	on			10d. Inside City Limits
	SC Sumter		Sumter				1 X Yes 2 No
th the Maryland 23a or 28a-f sho notified at once al Director	10e. Street and Number			10f. Zip Code	10g	. Citizen of What Coul	ntry?
vith the		et, Lot #1	rin IIS 13 Was	29150 Decedent of Hispanic Origin?	Specify Ves or No.	USA	can Indian, Black,
r death with or items 23 must be no	1 Never Married 2 Marrie		If Ye	s, specify Cuban, Mexican, Pue		White, etc.	carringari, black,
s after ral", o	3 Widowed 4 X Divorce	ed If Yes, Give Year	1	Yes 2 X No specify:			ite
2 hour "natu		only highest grade complet College (1-4 or 5+)	ted) 16a. Decedent during mo	s Usual Occupation (Give kind st of working life. DO NOT use	of work done 1 retired)	6b. Kind of Business/I	ndustry
5-0036 ed within 72 hour ofference other than "natu the Medical Exan Completed	12	,	Carpe	nter/Construct	ion	Construct	ion
filed w Hygie d other					me (First, Middle, Ma	,	
T 2 2 2 1 0			19b. Mailing	Lena Address (Street and Number of	Ray Hayes		Zin Code)
O & B in E L	Lena Dickinson			Broad St. Lot			, 2.5 0000)
45 6 8 2	20a. Method of Disposition 1 Burial 2 X Cremation 3		20b. Place of Disposit crematory or other	ion (Name of cemetery, er place)	Date 2	20c. Location - City or	Town, State
Baltimore, permit, Pages 1 ar Department of Hee Important: If ite injury or other tr	4 Dohation 5 Other Specia			an Crematory 1			and the same of the same
Baltimore permit. Pages 1 Department of E Important: If injury or other	21. Signature of Funeral Service Lice	ensee Nd Ql	22. Na	me and Address of Facility	Elmore Hi Sumter, S	ll McCreig C	ht FH
Physician /Medical	23a Part I. Enter the disease, or confailure. List only one cause on	plications that caused the each line.	death. Do not enter the	e mode of dying, such as cardia	c or respiratory arrest	, shock, or heart	Approximate Interval Between Onset and
Examiner	Immediate Cause (Final disease or condition resulting in death)	Hypertensic Due to (or as a conseque		scular Disease			Death
Margar V		Due to (or as a conseque	nice or).				
miner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conseque	nce of):				
-1 2	(Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	nce of):				
xecute n and l-tran	X UNPENDED		7 nor mo c	920 10-14-11 s	-		
760, icate be executed the burial - transit	IF FEMALE:	23c. If yes, outcome of		920 10-14-11 S	ш	23d. Date of delivery	<u> </u>
Division of Vital Records, P.O. Box 68760, To the Haspital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transiedical Certification: To Be Completed by Physician/Medical E.	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknow	1 Live birth 4 Pregnant at time	2 Feta	Il death 3 Ectopic preg	gnancy	,	ay Year
s, P.O. If ires that the signed by the detached by the detached by the detached by Ph	Part II. Other significant conditions	contributing to death but	not resulting in the un	derlying cause given in Part I.	23e. Did toba	cco use contribute to	he cause of death?
S, P.(juires tha n signed Id be det						2 No 3 Prob	
Records, The law require ficate has been sign, page 2 should be					24a. Was an autopsy performe	prior to c	topsy findings available ompletion of cause of
tal Reco	05.14				1 ✓ Yes 2	No 1 ✓ Ye	s 2 No
Vital ysician ysician directo	25. Was case referred to medical examiner?	Hospital: 1 Inpatient	2 🗸 ER/Outpatient	26.Place of Death (Chec		sidence 6 Other	
of Vision Physical Control of Con	1 Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Inj		28d. Describe how		
ion ttendi death. ttor: // the fu	1 X Natural 5 Pending 2 Accident Investiga			1 Yes 2 No			
Division of Vital Records, To the Haspital or Attending Physician: The law require within 24 hours after death. To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should bedical Certification: To Be Completed	3 Suicide 6 Could no determine	28e. Place of Injury -	At home, farm, street,	factory, office building, etc.	28f. Location (Stre or Town, State		al Route Number, City
Divi	[0.100.10.10]		-	ed at the time, date and place, a n, in my opinion, death occurre			
Z c H s H	29b. Signature and title of certifier	1/2		29c. License number	1_	9d. Date signed (Mor	th, Day, Year)
	alle Bro	roelf Mt		O.C.M.E.		October 1, 2011	
R2		ssistant Medical Exa	aminer 900 W.	Baltimore Street, Baltim	nore, MD 21223		
State Registrar	31. Date filed (Month, Day Year)	32. Registras Si	gnay				

DHMH 17 Rev 1/2001 OCME 2006

Alexandria, Virginia Molesworth-Williams, P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Or introduced at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year 179925214 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Derwood, Maryland Ahmed Heshmat, MD Millrun Drive 7133 Registrar's Signature DHMH 17 Rev 7/2009 **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

32697

11:16 PM

9. Birthplace (State or Foreign

10d. Inside City Limits

1 Yes 2 X No

21704

Mary Land

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ 5:50 Rose Marie Roberts September Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery National Institutes of Health Bethesda If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex Age (In vrs. last birthday) Funeral Country) Jamaica Days Hours 1 - M 2 K 1270671968 42 Director Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at filed within 72 hours after death with the Maryland Director 1 Yes 2 No Greater Portmore, Jamaica None None 10f. Zip Code 10a. Citizen of What Country? 10e. Street and Numbe Funeral Jamaica Lot 585, 2 North East Ascot None 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc. Completed by 1 Never Married 2 X Married 1 ☐ Yes If Yes, Give 2 XNo Saltimore, Maryland 21215-0036 1 Tes 2 No Specify: Specify: Black 3 - Widowed 4 - Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Private Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I-Important: If item 27 is marked of any injury or other traumatic even once. and Mental h 2 May Edwards Daniel Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jamaica 2 North East Ascot, Greater Portmore 585, Rohan Roberts/ Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Red Ground St. Catherine 10/3/2011 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Pope Funeral Homes, P.A. Signature of Foneral Service License Lana 5538 Marlboro Pike, Forestville,MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Qnset and Death Immediate Cause (Final Physician/ MO disease or condition Medical resulting in death) . Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death been signed by the sale 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Bacterenia Klebsiella 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? 1 Yes 2 No this certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No မြ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death Certificate: Date of injury 28b. Time of s after death. 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) work? injury 1 Natural 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the unite, date and place, and due to the cause(s) and manner as stated.

3 Certifying purese ractioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cer 29d. Date signed (Month, Day, Year)

State

Registrar

David

31. Date filed (Month, Day, Year, SEP 3 0 2011

MD

30. Name and address of person who completed cause of death (nem 23a) (Type, Print)

Halverson

166270

10 Center Drive, Bethesda, MD 20892

26

2011

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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should and N is ma		19a. Informant's Na	ame/Relationship	(Type, Print)		19b. Mail	ing Address (Street and N	lumber or Rural	Route Number,	City or Town,	State, Zip	Code)
nd 2 s ealth m 27		Gay P. S		fe			Tudor Lane	, Rockv	ille, M			
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.		20a. Method of Disp 1 🖾 Burial 2		☐ Removal from Sta	te C6	em <i>etery</i> , c <i>r</i> e	osition (Name of matory or other place)	Cont	ate . 28	20c. Location	n - City or T	own, State
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permi Depar Impo any ir		21, Signature of Pu	heral Service Lice	ensee	. /	Į	2. Name and Address of Francis J.Co	Illins F	uneral	Home I	nc.	MD 20001
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affect death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial transfer.	Medical						occured at the time, date stigation, in my opinion, de					ted. ause(s) and manner stated.
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		ANTHO	R SCH	ROZDENZI	D Hou	nc Phy	Sicure 705 Day	tel Dr.	Linth	1cum	MI)	21010
Stat		31. Date filed (Monti	h, Day, Year) 28 201°	32. Regis	rar's Signat	ure	2.5.			10		
Registra	all	2FL	40 201	Rusan	, p.	7						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Grayson Glenn Smith 2011 September 10:50 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 7511 University Road Boonsboro Washington Social Security Number 8. Date of Birth (Month, Day, Yea 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 X M 2 1 Months Hours Min. Country)
Maryland 215-26-8521 **Director** 82 Feb. 6, Usual Residence of Decedent 28a-f show filed within 72 hours after death with the Maryland al Hygiene. of other than "natural", or items 23a or 28a-f show 10b. County "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 X No Maryland Washington <u>Boonsboro</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7509 University Road 21713 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force þ 1 Never Married 2 X Married Black, White, etc. ☐ Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced If Yes, Give Specify: Completed Year or Dates White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the 11 Operator Manufacturing Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental H Important: If item 27 is marked ot any injury or other traumatic ever 18. Mother's Name (First, Middle, Maiden Surname) ည Grayson 0. Smith Anita M. Toms 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glenna M. Moncrief/daughter 7511 University Road Boonsboro, Maryland 21713 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/01/2011 Boonsboro, Maryland Boonsboro Cemetery 21. Signature of Funeral S 22. Name and Address of Facility Bast-Stauffer Funeral Home, PA 7606 Old National Pike Boonsboro, MD 21713 Enter the disease, or complications that or heart failure. List only one cause on each caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Ongestive disease or condition Medical resulting in death) Due to (or as a con quence of Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Ordenying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and-tran Due to (or as a consequence of): resulting in death) Last burialattending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death 2 No ed by the a 9 Unknown 9 Unknown signed by be detail Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed' certificate 10 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be funeral director, 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Yes 2 →No Other: 잍 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 24 hours after death. Funeral Director; A Accident 1 ☐ Yes 2 ☐ No Investigation completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2' Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 the only one 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mi 10 - Wt 22911 Kerns Just 31. Date filed (Month, Day, Year State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Richard Lee Slota Sep 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Worcester <u>Berlin</u> Anchor Way Dr 8. Date of Birth 7. Age (In yrs. last birthday If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months M 2 □ F Days Hours Min. Country) $1 \times$ Director 3-14-1947 206-38-582 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Worcester Berlin 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 16 Anchor Way 21811 USA Dr 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No Navy Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes Give Specify 3 Widowed 4 Divorced Year or Dates white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Manager Mini Storage Department of Health and Mental Hygien Important: If Item 27 is marked any injury or a Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, 2 Andrew Slota Lula Rose 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia M. Slota-Wife 16 Anchor Way Dr. Berlin, MD 21811 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) /29^{Date} 20c. Location - City or Town, State 1 ☐ Burial 2 💆 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) First State Crem. Millsboro, DE 21. Signa proof Funeral Service Licensee 22. Name and Address of Facility Burbage Funeral Home 108 William Street Berlin, MD Part a. Enter the disease, or complications shock, or heart failure. List only one cause 23a. Part ... at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner - Small cell Sequentially list conditions, if any, leading to immediate cause. Enter Underlying ending physician and use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
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1 ☐ Yes 2 ☐ No for Month Pregnant at time of death 5 Other (specify) Day Year ed by the a detached f 9 Unknown 9 Unknown P.O. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobage use contribute to the cause of death? \$ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? autopsy this certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 No Other: 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home in 24 hours after death.

De Funeral Director: After this pleted filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 5 Pending 2 🗌 No Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hou To the Fune completed fi (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature a title of certifier 29d. Date signed (Month, Day, Year) of person who completed cause of death (Item 23a) (Type

State Registrar 31. Date filed (Month, Day, Year)

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oe executed cian and ourial-transit	Examiner	Cause (Disease or that initiated events resulting in death) I	5	C	/		uence of):										
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eath certi attending for use a	N.	IF FEMALE: 23b. Was deceden	it pregnant	23c. If yes, ou				_						23d. Da	ite of de	iverv	
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at the deby the stached	hys	9 □ Unknown		9□Unkn	own												
res tha signed b	by F			ons contributing to d	eath bu	t not resu	ulting in th	e underlying	cause give	en in Part	I.					the cause of death?	
w require been sign	Completed	CAD, IDI	DM, CVA	J								1[]	Yes 2	No No	3∐ Pi	robably 4	wn
e law nas b	nple											24a. Was	psy		prior to	utopsy findings availa completion of cause	ble of
: The lav cate has ; page 2 s	Co											perf 1□ Yes	ormed? 2 X No		death? 1 ☐ Yes	2 □ No	
sician: Th certificate rector, pag	Be	25. Was case refer examiner?		Hospital:					Oth		e of Dea	th (Check only	one)				
ding Physician: n. After this certific funeral director,	: To	1 ☐ Yes 2 【 27. Manner of Deat		28a. Date			ER/Outpa 28b. Tim	tient 3∏ [e of	JOA	4 LI N	ursing He	ome 5 X Res 28d. Describe				cify)	
nding th. :: Afte e fune	tion	1 XNatural 2 ☐ Accident	5 Pendin investi	ig (Mon	nth, Day	Year)	Inju	ry M	28c. Injur Wor 1 □	k? Yes 2 ⊑]No			,			
or Attending Physician: after death. Director: After this certifica i in by the funeral director, i	ifica	3 ☐ Suicide 4 ☐ Homicide	6 Could determ	inad Zoe. Flate	of inju	ry - At ho . <i>(Specif</i>)	me, farm,	street, facto	ory, office						ber or R	ural Route Number,	
tal or s afte al Din ed in	Certification:			Dund	mg, etc.	. (Opecin)	′/					City or To	wii, Stat	0)			
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	29a. Certifier (Check only		ng Physician: To the Examiner: On the b													
thin 2,	Med	one) 29b. Signature and	title of Artific	and man	ner stat	teld.		7	9c. Licens	e number			204 Da	ato ciono	od (Mon	h, Day, Year)	
To with	_	250. Signature and		1. /	2	1	5/	1						_			
`		30. Name and addr	ress of person	who completed caus	se of de	ath (Item	23a) /Tvi	\	00034	23I	<u> </u>		Sep	cemb	er 2	29, 2011	
	4			124 Mill		,	, , , ,	, ,	le, N	1D 2	1536	;					
Sta	_	31. Date filed (Mon						par									
Registr	ar		901	A	1		1	7									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 15 per fh g920 10-19-11 vt
State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of I	Marylai				lealth an Death	nd Me	ntal Hy	/gien Reg. N		1 /	00700
		21	1. Decedent's Name (First, Middle,	Last)	, -					2	Date of D	eath	201	1	. Time of Death
	nysici: 'Medic		MARGARITA HAL	L STEPHEN	S					s	Month eptem	ber	^{ay} 23,201		2:25 P M
ACCOUNT OF	xamin		4a. Facility Name (If not institution, g		er)		4b. Cit	y, Town, o	r Location of E				c. County of D		
				AVE.				SUIT	LAND			F	PRINCE	GEO	RGE'S
	neral ector		5. Social Security Number 171-30-2325	. Sex 7 1 ☐ M 2 ☑ F	Age (In yrs. 81	. last birthday) Yrs.	If Und Month	er 1 Year s Days	If Under 24 Hours		Date of Bi (Month, D)	rth ay, Year 1930	9.	Birthplac Country)	e (State or Foreig) FL
P .			Usual Residence of Decedent												
arylar	dal	_	10a. State 10b. County		10c. C	ity, Town or Lo	cation							10d.	Inside City Limits
9 W	elli.	cto	Maryland Prince	George's		Suitla	nd								1X Yes 2 No
∯ 9	20	Director	10e. Street and Number				10f. 2	ip Code				10g. C	itizen of What	Country	?
ath v	inst	B		AVE.				207				UNI		CATES	
er de	Dage	nue	11. Marital Status	12. Was Decede Armed Force	s?		Was Dec If Yes, sp	edent of F ecify Cub	lispanic Origin an, Mexican, F	n? (Specif Puerto Ric	fy Yes or N can, etc.)	0-	14. Race - A Black, V	merican /hite, etc.	
21215-0036 d within 72 hours after death with the Maryland giene.	or other traumatic event, the Mudical Evandrat must be nutified at	Completed by Funeral	1 ☐ Never Married 24 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 21 If Yes, Give Year or Date:			1 🗆 Yes	3 € No	Specify:				Specify:	BLAC	CK
5-0 72 hg	lical	sted	15. Decedent's (Specify only highest of	Education		16a. Dece	dent's Us	ual Occup	ation during most of	f working		16b.	Kind of Busine	ss/Indus	try
within 5	Me	d d	Elementary/Secondary (0-12)	College (1-4c	r 5+)	life.	DO NOT	use retired	d)	_			OC	arroo	T GTTGTT
d 21 filed w	2	Con		4±		ELEME	NTAR	Y SCI	HOOL TE	EACHE	IR .	Pu	BLIC S	CHOO	L SYSTEM
Maryland 2121 of 2 should be filed within the and Mental Hygiene. To se marked other than	Nev	Be	17. Father's Name (First, Middle, La	st)					18. Mother's			e, Maide	n Sumame)		
Went was	atlc	2	EUGENE HALL SR.						TECC	ORA C	LARK				
2 shot and and	mne .	ĺ	19a. Informant's Name/Relationship			19b. Mailir	ng Addre	ss (Street	and Number o	or Rural R	Route Numb	er, City	or Town, Stat	e, Zip Co	ide)
ore, M es 1 and 2 of Health	er tr	ļ	BERNARD STEPHENS	/HUSBAND					AVENUE,	SUIT	CLAND		MD 20	746	
O SET	io i		20a. Method of Disposition 1	☐Removal from State	. ! .	Place of Dispo cemetery, crer	natory of	other place	сө)	Date			ocation - City		
Baltimore, bermit. Pages 1 at Department of Hea	ury		4 Donation 5 Other (Spec		Ma	ryland	Vete	rans	enham C	3/29/	/2011	Che	Itenhar	. M	arvland
Baltimo permit. Pages Department of Important: If I	any Inj		21. Signature of Funeral Service Lic	ensee M. C	0981	22	. Name	and Addre	ss of Facility	POPE	FUNE	RAL	HOMES,	P.A	aryland
m &ă.E	= 9		Charles E	your	7		5538	MARI	PROKO B	TKE,	FORE	STVI	ILLE, M	ID 20	746
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	molications that causely one cause on each	ed the dea	th. Do not ent	er the m	ode of dyin	ig, such as cai	rdiac or re	espiratory a	arrest,			oproximate terval Between
Physic	cian		Immediate Cause (Final disease or condition			Disea								Or	nset and Death
/Med			resulting in death)	Due to (or a			30								
Exam	iner		Commentation first and the same	h											
7	-	ner	Sequentially list conditions, any Isaang to Invade late cause. Enter Underlying Cause (Disease or injury	Due to (or a	is a richson	quarios of):									
cutec	ransi	Examin	that initiated events	c.											
O , exe	rial-t		resulting in death) Last	Due to (or a	s a consec	quence of):									
(8 / 60, cate be executed physicien and	s the burial-transit	dical		d											
riffica 19 ph		⊕ ⊢				2000									
Geath certific e attending p	esu .		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			35-4:-						23d. Date of	delivery	
. 0 0	of for		in the past 12 months? 1 ☐ Yes 2 ☑ No	4☐Pregnant	at time of c		Other (pregnancy specify)					Month	Da	y Year
at the de	tache	χ.	9 Unknown	9□ Unknown											
- 2 0			Part II. Other significant conditions	contributing to death	but not res	sulting in the ur	nderlying	cause giv	en in Part I.		23e. Did	tobacco	use contribut	e to the c	ause of death?
aduire an sig	should b	8	Coronary Artery	y Disease							1 🗆	Yes 2	2 √ No 3□	Probabl	y 4 Unknowr
law requast been	sho :	Completed by	Type II Diabete	e Mellitu	C						24a. Was	an	24b. Were	autopsv	findings available
The Te ha	page		1/90 11 0140000	33 IICITICA						-	auto perf	psy ormed? 2 N	prior	1?	etion of cause of
	ō	a l	25. Was case referred to medical						00. Place of	De alla de			0 1 1 1	/es 2[∐ No
Of VITA Physiclan: this certific	Ē .	0	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Dippa	tient 2	ER/Outpatien	t 3 🗆 🖸	Oth	26. Place of				6 □Other (5	2(-)	
	= '	=	27. Manner of Death	28a. Date of In	jury	28b. Time of		28c. Injun Worl	4 1401511				iny occurred	респу)	
Attending I r death. ector: After	un e	91	1 Natural 5 Pending 2 Accident investigati	(Month, E	ay Year)	Injury	м		k? Yes 2∐No						
or Attending after death.	by the	Ĕ	3 ☐ Suicide 6 ☐ Could not	d 286. Place of I	njury - At h	ome, farm, stre	et, facto	ry, office		28f			nd Number o	r Rural Ri	oute Number,
a a a a a a a a a a a a a a a a a a a	<u>⊆</u>	Certification:	4 Homicide determine	building,	etc. (Specil	TY)					City or To				
• Hospital 24 hours a • Funeral I	completely filled in by	E I	29a. Certifier 1 X Certifying F	Physician: To the bes	t of my kno	owledge, death	occurre	d at the tin	ne, date and p	otace, and	due to the	cause(s	s) and manne	r as state	d.
7 54 F	letel	edical	(Check only 2 Medical Exa	amined: On the basis and manner s	of examina	ation and/or inv	estigation	n, in my o	pinion, death o	occurred	at the time,	date ar	nd place, and	due to the	e cause(s)
To the within 2	Com		29b. Signature and title of certifier	1//	/		2:	c. License	e number			29d. D	ate signed (M	onth, Day	v, Year)
				1 Kml]	00037	529			C	1/27	///	
0			30. Name and address of person whi	completed cause of	death (Item	n 23a) (Tvne	Print)						1 10.1	' /	
_ 1			Ronald Wheeler,					a. T.a	reo. M	. 20	774				
	State		31. Date filed (Month, Day, Year)	32. Regis	trar's Sign	and I		-, па	- 50 PH	20,	, , ¬				
Re	gistra		SEP 3 0 2011	Musel A	9. 4	ack									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			for State		State	of Mar	yland / Dep			Mental Hy	giene	00701
			Registrar 1. Decedent's Name	/Einst Middle	(act)		Ce	rtificate of i	Jeath		Reg. No.	32/04
	Physicia		LUCY		ONA	SAVIL	TD			2. Date of De Month	ath Pay Year	3. Time of Death 1550 M
PAGE.	Medi Examir		4a. Facility Name (if n				712	4b. City. Town, o	r Location of Dea	th	4c. County of De	7 1 7 9 9
-	}		Western N	D Reg	ional Me	dical	Center		mberland		Alleg	
	Funeral		5. Social Security Nur		6. Sex 1 ☐ M 2 🛣		n yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	8. Date of Bir	th a B	irthplace (State or Foreign
	Director		235-32-63 Usual Residence of D		1 🗆 101 2 🕰		85 Yrs.	Wieriano Bayo	T TOURS	Januar	ý 30, 1926	Burlington WV
	and show	0		10b. County		10	Oc. City, Town or Lo	cation				10d. Inside City Limits
	Maryli 8a-f ntifiec	rect	WV	Mine	eral		Keyse	r				1 🔀 Yes 2 🗌 No
	a or 2	<u>E</u>	10e. Street and Numb	per				10f. Zip Code			10g. Citizen of What C	Country?
	h with	Funeral Director	500 Cars	kadon	Lane, A	pt. 20)1	2672	26		USA	
	r deat		11. Marital Status 1 Never Marrie		Armed	ecedent Ever Forces?		Was Decedent of H	lispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Wh	
036	s after al", o Exam	q p	3 Widowed 4		led 1 ∐ Ye If Yes, ∀ear or			1 ☐ Yes 2 🌠 No	Specify:		0	White
2-0	e filed within 72 hours after death with the Maryland tral Hygiene. 94 other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed by	/S-noni	15. Deceden	t's Education			dent's Usual Occup			16b. Kind of Busines	
21	hin 72 he. than *	mo	Elementary/Secon		St grade complete	e (1-4 or 5+)		kind of work done O NOT use retired)	during most of wo	orking		
72	ed within Hygiene. other tha ent, the P	BeC	12					Cook			Elementary	School School
Baltimore, Maryland 21215-0036	be filed ental Hy ked oth ic event	10 E	17. Father's Name (Fit Blaine N		,					ame <i>(First, Middl</i> e, abeth An1	Maiden Surname)	
ary	should be file h and Mental h 7 is marked o raumatic eve		19a. Informant's Nam				10h Maili	na Addrana (Ctroat			r, City or Town, State, 2	Tin Codel
Š	(1 = N =		Raymond			er		1, Box 2		eyser, W		ip Code)
ore,	ge 1 and it of Heal if item or other		20a. Method of Dispo	sition	<u>-</u>		20b. Place of Dispo	sition (Name of		Date	20c. Location - City of	or Town, State
<u><u>H</u></u>	permit. Page 1 Department of Important: If i any injury or once.		1 🔀 Burial 2 □ 4 □ Donation 5	Cremation Other (S)	3 □ Removal fro pecify)		Stone Cha	natory or other place pel Cemet	UCL	· 7 011	Burlington	ı. WV
3alt	ermit. Pepart nport ny inj nce.		21. Signature of Fune	ral Service Li	cense	-111					eral Home	
	⊕ # # O		10	Wan	DE	M	8.	5 S. Mair	Street	Keyse	c, WV 2672	.6
				allure. List or	complications that ly one cause on	at caused the each line.	e death. Do not ente	^		c or respiratory an	rest,	Approximate Interval Between
7	Physician/ Medical	2 N	Immediate Cause (Fir disease or condition resulting in death)	nai	a	leta	volic	Haid	6513			Onset and Death
mary!	Examiner		,	- 1	Due	to (or as a co	nsequence of):	hock				
		ner	Sequentially list cond	culate 2	b. Due l	to (or as a co	inScullence on					
	uted id ansit	ami	cause. Enter Underlyi Cause (Disease or iin that initiated events	ing jury	. Se	POSIS	from	Acut	e Ryela	nephr,	His	
	exectian ar	dical Examiner	resulting in death) Las	st	Due t	d (or as a co	nsequence of):		,	7		
90	Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and sted filled in by the funeral director, page 2 should be detached for use as the burial-transit.	dic		•	d	tro	Ke					
Box 687	ath certifica attending pl I for use as tl	Completed by Physician/Me	IF FEMALE:		23c. If <u>ye</u> s, c	outcome of n	reanancy		***************************************			
ŏ	atten I for u	ciar	23b. Was decedent print in the past 12 mo 1 ☐ Yes 2 🔀 I	nths?	1 Liv	ve Birth 2 egnant at tim	Fetal death 3	Ectopic pregnand Other (specify)	У		23d. Date of d Month	elivery Day Year
B	the de sy the	hysi	g Unknown	NO	9 □ Ur			z carior (opcony)				
P.O.	es that the dea signed by the a I be detached f	by P	Part II. Other significa	ant condition	s contributing to	death but n	ot resulting in the u	nderlying cause giv	en in Part I.	23e. Did to	obacco use contribute t	to the cause of death?
ds,	v requires been sig should b	ted			-					1 🗆	Yes 2 No 3	Probably 4 Dunknown
COL	law re has be je 2 sho	Jple	v							24a. Was		utopsy findings available completion of cause of
Division of Vital Records,	Physician: The lar r this certificate ha ral director, page 2	Sol								perfo	rmed? _ death?	es 2 No
ţa	ician: certific ector,	Be	25. Was case referred examiner?		Hospital:			1011	ace of Death (Che	eck only one)		
<u></u>	Phys	2	1 Yes 2 2	<u> </u>	1 1	Inpatient te of injury	2 ER/Outpatier		4 ∐ Nursing	1	dence 6 Other (Spe	ecify)
o u	al or Attending Phy s after death. I Director: After this d in by the funeral o	Certificate:	_ /	Pending	(Mo	onth, Day, Ye		l28c. Injury work M 1 □		28d. Describe h	ow injury occurred	
Sic	Atter	ΞĮ		6 Could no	ot be 28e. Plac	ce of Injury -	At home, farm, stre		100 2 2 110	28f. Location (S	itreet and Number or R	ural Route Number,
<u> </u>	tal or rs afte al Dir		. — Hallmords	40.0711111	buil	ding, etc. (S _t	pecify)			City or Tow	n, State)	
	Hospi 4 hou Funer ted fill	edical	29a. Certifier 1 1 (Check 2	Certifying F	hysician: To the	best of my l	knowledge, death o	occured at the time	date and place,	and due to the car	use(s) and manner as s	tated. cause(s) and manner stated.
		Σ	only one) 3 29b. Signature and title	Certifying N	Nurse Practione	r: To the best	of my knowledge, o	leath occurred at the	e time, date and pl	ace, and due to the	e cause(s) and manner a	s stated.
	5 1 8 E		-		rk. Ch	044/1	walle	29c. License	0 6 78		29d. Date signed (Mon	
		ŀ	30. Name and address				-			70	10/5/20	7[1
3	V							, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		l Cumber	land, MD 2	1502
Ĺ	State	-	31. Date filed (Mornin, 1	Day, Year)	32	Registrar's S		wed .			-,	
	Registra	r	00	T 1 3	2011 2	reur	p. Ala					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 11:30a M Physician/ Marcos Torres Sept. 21 pa 011 Year Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Olney Montgomery Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 626-05-6164 Hours Min. 41/249741941 70 Director Costa Rica Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 10d. Inside City Limits MD Montgomery Silver Spring 1 🗆 Yes 2 🖺 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3624 Pear Tree Court #13 20906 USA 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Costa Rican 14. Race - American Indian. Armed Forces? Black White tete 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Completed by 1 Yes 2 □ No Specify. If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 9 Elementary/Seconday (0-12) College (1-4 or 5+) Mechanic Mechanics Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Juan Ramon Torres Carmen Castillo 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) on 3624 Pear Tree Court #13 Silver Spring, Md Rosa Maria Zeledon/Companion 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place)
Gate of Heaven injury or 9/28/2011 Silver Spring, Md 4 Donation 5 Other (Specify) 21. Signatur o Funeral Service Lice PHILIPAD STANALDI FUNERAL SERVICE, P.A 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Examiner Sequentially flet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated as of the cause (Disease or iinjury that initiated as of the cause (Disease or iinjury that initiated as of the cause (Disease or iinjury that initiated as of the cause (Disease or iinjury that initiated as of the cause (Disease or iinjury that initiated as of the cause (Disease or iinjury that initiated as of the cause (Disease or iinjury that initiated or in Examine to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and deelached for use as the burial-trathat initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No ၉ 1 🗌 Yes Other: 1 Nnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manur of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 \square Pending injury work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) D0068026 21 12011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PADMAJA Princ deil 18101 Ine

State

Registrar

31. Date filed (Month, Day, Year)

SEP

28 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	State of Maryland / Department of Health and Mental Hygiene									
	1 - State Registrar Certificate of Death							Reg. N ₂ 20 32708		
п	Physicia	ın/	1. Decedent's Name (First, Middle, Last) Linda Winslow				2. Date of Dea Month	_	Year 2030 PM	
party.	Medic Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location of De		23 a		
2000	LAGIIII	iei	Montgomery General Hospital		01ney	Eccation of De	Saur	Montg		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. la	st birthday)	If Under 1 Year Months Days	If Under 24 H	Hrs. 8. Date of Birt	h I	Birthplace (State or Foreign Country)	
	Director		006-50-5409 Usual Residence of Decedent 1 ☐ M 2X F 64	Yrs.	Wionario Bayo	Triodio Tri	JAN 25		ME	
	and show I at	ō		, Town or Loc	cation			,	10d. Inside City Limits	
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	th the 3a or the n		10e. Street and Number		10f. Zip Code			10g. Citizen of W		
	ath wi	Funeral	51 Village Green Road 11. Marital Status 12. Was Decedent Ever in U.S	10 1	04901	enania Origin?	(Specify Yes or No-	United		
9	or ite	by F	Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No	If	Yes, specify Cubar	n, Mexican, Pu	erto Rican, etc.)		e - American Indian, k, White, etc.	
003	ursaff tural", al Exa	ted	3 X Widowed 4 □ Divorced If Yes, Give Year or Dates.	1	Yes 2 No	Specify:		Specify:	Caucasian	
15-	72 ho n "nat	Completed by	15. Decedent's Education (Specify only highest grade completed)	(Give k	ent's Usual Occupa ind of work done do ONOT use retired)		working	16b. Kind of Bu	siness/Industry	
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nd	filed val Hyg	Be C	17. Father's Name (First, Middle, Last)			18. Mother's N	Name (First, Middle, i	Maiden Surname))	
yla	uld be I Ment narke natic €	욘	Miles Standish Dickinson	-		There	sa Jane	Flagg		
, Maryland 21215-0036	d 2 shoralth and 127 is r		19a. Informant's Name/Relationship (Type, Print) Melanie O'Leary / Daughter				Rural Route Number ce, Gaithe		tate, Zip Code) MD 20882	
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 Burial 2 Cremation 3 Removal from State C6	emetery, crem	sition (Name of atory or other place Crematory	v 09/	Date / 27 / 2011		City or Town, State	
Baltiı	permit. P Departm Importal any injur		21. Signature of Funeral Service Mensee	22	Name and Addres nibadeau	s of Facility Mortua:	rv Service	e. p.a.		
			M00956		/ Park Avenue, Galthersburg, MD 208				20877 Approximate	
	Physician/		23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final							
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	Examiner	J.	Immediate Cause (Final disease or condition resulting in death) Due to (of as a consequence of): CANDIOMYDPATHY Due to (or as a consequence of): CHOUSE OF A STAT							
Т	p 12	/Medical Examiner	if any, leading to immediate Due to (or as a conseque cause. Enter Underlying Cause (Disease or injury	(t .)	0					
	execut in and ial		that initiated events c. Due to (or as a consequence of):							
09	death certificate be executed ne attending physician and ed for use as the burial		d							
387	artifica ling ph		IF FEMALE:					1		
P.O. Box 687	eath certifica attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1	death 3	Ectopic pregnancy Other (specify)	У		23d. Date Mon	e of delivery hth Day Year	
о В	requires that the der been signed by the s should be detached	hysi	1 Yes 2 No 4 Pregnant at time of do	Jan 0 12						
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<u>а</u> Н	ysician; Tł is certificat director, pi	Be C	25. Was case referred to medical		26. Pla	ce of Death (C	1 🗌 Yes	2 No 1	☐ Yes 2 MNo	
₹	Physic this ce ral direc	인	examiner? 1 ☐ Yes 2 🔀 No Hospital: 1 🔀 Inpatient 2 ☐ E	ER/Outpatient	3 DOA Other	r: 4 Nursing	g Home 5 🗆 Resid	ence 6 🗆 Other	r (Specify)	
n of	ding P	ate:	1 Natural 5 Pending (Month, Day, Year)	28b. Time of injury	28c. Injury work?	_	28d. Describe ho	ow injury occurred	d	
Division of Vital Records,	Il or Attenc after deatl Director: d in by the	Certificate:	2	ne, farm, stre		Yes 2 No	28f. Location (Si	treet and Number	r or Rural Route Number,	
	ital or irs afte al Dire		building, etc. (Specify)				City or Town			
	To the Hospital or Attending Physician; The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach	Medical	29a. Certifier (Check 2 Medical Examiner: On the best of my knowle only one) 3 Certifying Nurse Practitioner: To the best of my knowle	and/or investi-	gation, in my opinior	n, death occurre	ed at the time, date ar	nd place, and due	to the cause(s) and manner stated.	
	of seith	_	29b. Signature and title of certifier Bichhum M Ginh		29c. License	number (4996	2	Septemb	(Month, Day, Year) Lr 95 2011	
			30. Name and address of person who completed cause of death (Item 2	23a) (Type, Pr O hu	int) Bichhu	-	Jinh, M.D			
	Stat	_	31. Date filed (Month, Day, Year) 32. Registrar's Signatu	_	e.1	みつひろん				
	Registra	r	SEP 28 2011 Person A.	gas	-					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Ruston illiamson Medical 9 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death County of Death Julia Manor Health art. Cer Haberstau 2 5. Social Security Number Sex 1 X M 2 □ F Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth 216-14-6465 Sep. 17.1923 Hours Mary Land **Director** 88 Usual Residence of Decedent 10a. State with the Maryland notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 28a-f Maryland Washington County Hagerstown 1 ☐ Yes 2 X No 10e. Street and Number ō 10f, Zip Code 10g. Citizen of What Country? must be Funeral 23a 10842 Rosewood Dr. 21740 U.S.A. items ? permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 X Widowed 4 ☐ Divorced Completed Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Contract Painter Self Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Humor Williamson Dorothy Zumbro Williamson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Wittenmyer-daughter 10842 Rosewood Dr. Hagerstown, MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 9-29-2011 Cedar_plawn Memorial Hagerstown, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Exami the burial-transit and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 33 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Day Pregnant at time of death 2 No ed by the detached Unknown 9 Unknown signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Ś Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🙀 Unknown Completed 24b. Were autopsy findings available 24a. Was an page 2 s prior to completion of cause of death? autopsy performed? this certificate 2 No Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: ၉ 1 🗌 Inpatient 2 🗆 ER/Outpatient 3 🔲 DOA 4 X Nursing Home 5 A Residence 6 Other (Specify, funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: within 24 hours after death.

To the Funeral Director: After of the funeral filled in by the funeral funeral filled in by the funeral filled in by 28c. Injury at 28d. Describe how injury occurred work? 1. Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🔀 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JW - 16 State

Registrar

DHMH 17 Rev 7/2009

Naden

31, Date filed (Month, Day, Year)

333 Mill Staret, Hoverstouch, ND 21740

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 32708 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 28^{Day} Month 201Î 11:07AM James Franklin Watts Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Atlantic General Hospital Berlin Worcester Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 **X** M 2 □ F Days Hours 1922 1922 **Director** 215-18-8591 89 Country) MD Usual Residence of Decedent show be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits notified 28a-f 1 X Yes 2 No MD Worcester Ocean City 10e. Street and Number ò 10f. Zip Code ms 23a or must be r 10g. Citizen of What Country? Funeral 140 Channel Buoy Rd. 21842 USA tems 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces?

1 X Yes 2 No Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: "natural", Completed 3 Widowed 4 Divorced white permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical Lonce. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Vice President Union Trust Bank 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Alexander F. Watts Bertha Sparks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evangelene Watts / wife 140 Channel Buoy Rd., Ocean City, MD 21842 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ other (Specify) First State Crem. 9/29/2011 Millsboro, DE 21, Shatur of Pun 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 700% disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physician and s the burial-trans Due to (or as a consequence of) Completed by Physician/Medical Box 68760 been signed by the attending partending partending by should be detached for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Day Pregnant at time of death Year Unknown Records, P.O. her significant conditions contributing to leath but no realiting in the underlying cars given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📈 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an the funeral director, page 2 autopsy Hospital or Attending Physician: The 124 hours after death. Funeral Director: After this certificate h 1 ☐ Yes 2 📈 No 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1 \sum Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ္ 1 N Inpatient 2 ER/Outpatient 3 DOA o 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural Division 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined ว 24 hours a e Funeral I Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Ture Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29b. Signature and title of cert 29d. Date signed (Month, Marme and address of person who comple d cause of death (Item 23a) (Type, Print State

DHMH 17 Rev 7/2009

Registrar

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James

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						4b. City, Town, or		f Death		4c. County of Dear		
É	Funeral		Garrett Co. 5. Social Security Number		spita. e (In yrs. last bi		Oaklar If Under 1 Year	1CI If Under 2	24 Hrs. 8 Dat	te of Birth		
į.	Director		218-24-8566	1 X M 2□ F	90	Yrs.	Months Days	Hours	Min. (Mo	onth, Day, Ye 29/192	ar)	thplace (State or Foreign ountry) Cyland
	and		Usual Residence of Decedent 10a. State 10b. Count	y	10c. City, Tow	n or Lo	cation					10d. Inside City Limits
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	th the	Director	10e. Street and Number				10f. Zip Code			10g.	Citizen of What Co	untry?
	ath wi		1790 Mosser	Road			2154	1			U.S.A.	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evanting cuts by notified at	by Funeral	11. Marital Status 1 □ Never Married 2X Ma 3 □ Widowed 4 □ Divorce	If Yes, Give			Vas Decedent of Hi fYes, specify Cuba □Yes 2 📉 No	ispanic Orig in, Mexican, Specify:	in? (Specify Ye Puerto Rican,	es or No- etc.)	14. Race - Ame Black, White Specify: 5.71	e, etc.
21215-0036	2 hour	ted !	15. Decede	ent's Education	16a	ı. Deced	lent's Usual Occupa	ation		16b	. Kind of Business	nite
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lore	0 0		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 Removal from State	20b. Place o	of Dispos ery, crem	sition (Name of natory or other place		Date		. Location - City or	
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Ba	permit. Departr Importa any Inju	Ų	21. Signature of Funeral Service	Mattengly	1	1	Name and Addres	er S	t., Gr	antsv		mes P.A. ID 21536
45	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death disease or condition									
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DIVISION	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s	Certification:	3 Suicide 6 Could 4 Homicide determ		ry - At home, fa (Specify)	rm, stre	et, factory, office			cation (Street y or Town, St		ıral Route Number,
	ne Hospi n 24 hour ne Funer oletely fill	edical	29a. Certifier 1 Certifyli (Check only one) 1 Medical	ng Physician: To the best of Examiner: On the basis of and manner state	examination ar	e, death	occurred at the time estigation, in my op	ne, date and pinion, deatl	d place, and due h occurred at th	e to the cause le time, date	e(s) and manner a and place, and due	s stated. to the cause(s)
	Mithii Comp		29b. Signature and title of certifie	1			29c. License	number		29d.	Date signed (Mont	h, Day, Year)
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	- 1	0	30. Name and address of person					0	1-1	7	7	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 23, 2011 1615 P Ronald Alfred Watson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Prince George's Hospital Center Cheverly If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Ye 1 🖾 M 2 🗆 F Days Months Hours Min Yrs. **Director** 1955 579-74-1919 Usual Residence of 28a-f show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🛛 Yes 2 🗌 No Washington DC 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? ms 23a or must be n Funeral 20019 1024 50th Street NE United States items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 Yes 2 No Black, White, etc. Ş 1 Never Married 2 Married ō filed within 72 hours after 3altimore, Maryland 21215-0036 Specify: African 1 Yes 2 No Specify: If Yes, Give "natural" 3 Divorced Completed Year or Dates <u>Ámerican</u> Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) event, the Private 9th Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) is marked o 1 and 2 should be find Health and Mental item 27 is marked ည Jane Elizabeth Weaver Samuel Rufus Watson traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P O Box 46434 Raleigh, North Carolina 27620 Rhonda Demetria Watson-Daughter injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of I Important: If its any injury or or ■ Burial 2 □ Cremation 3 □ Removal from State October Lincoln 4 ☐ Donation 5 ☐ Other (Specify) Suitland, Maryland Signature of Funcial Service Licenses 22. Name and Address of Facility Stewart Funeral Home, Feten 20019 Benning Road NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a ardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last attending physician for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death signed by the a g Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not regulting 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available 24a. Was an nas autopsy performed prior to completion of cause of death? certificate ha irector, page 2 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ ppatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred After Natural 5 Pending Accident 1 🗌 Yes 2 🗌 No s after death Investigation 3 Suicide 4 Homicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined within 24 hours a

To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and many 29b. Signature and title of certifie 29d. Date signe (Month, Day, Year, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of M	laryland / Depa			Mental Hy	giene		
			Registrar Certificate of Death Reg. No.							32711	
	Physici		Sylvester	Waters			2. Date of Death Month Day Year September 29, 2011 211				
	Medi Exami		4a. Facility Name (if not institution,			4b. City, Town, o	r Location of Deat		4c. County of Dea		
		М	Southern Mary				linton			Georges	
	Funeral Director	ı	5. Social Security Number 577-66-5754	5. Sex 1 🛣 M 2 □ F	ge (In yrs. last birthday) 61 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	. (Month, Da	v. Year) Co	rthplace (State or Foreign ountry)	
	MQ I	1.	Usual Residence of Decedent					March	6,1950	Wash.,DC	
	rryland a-f show ied at	ctor	10a. State 10b. County	-	10c. City, Town or Lo					10d. Inside City Limits	
	he Ma or 28a e notif	D ig	MD P	G	l Upr	per Marl	lboro		10g. Citizen of What C	1 X Yes 2 No	
	th with the Maryland ms 23a or 28a-f sho must be notified at	Funeral Director	4512 Sherborn	Lane		207	7 2		3	d States	
	dea ite		11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13. V	Vas Decedent of H	lispanic Origin? (S	pecify Yes or No- to Rican, etc.)		erican Indian,	
036	s after al", or Examin	d by	1 ☐ Never Married 2 🔀 Marrie 3 ☐ Widowed 4 ☐ Divorced	d 1 ☐ Yes 2 🛣 If Yes, Give Year or Dates.	No	☐ Yes 2 ☐ No			Specify:		
21215-0036	2 hours af "natural", edical Exa	Completed by	15. Decedent	s Education		ent's Usual Occup			16b. Kind of Business	ack	
121	thin 72 ene. than '	mo	(Specify only highest Elementary/Seconday (0-12)	College (1-4 or	life DI	ond of work done of NOT use retired)	dunng most of wo	rking			
9	lled wit I Hygie other ent, th	Be C	17. Father's Name (First, Middle, Las	2		<u>Host Se</u>)—·	ne Cimb State	Priva Maiden Surname)	te	
'lan	l be fil fental rked ic ev	၉	Richard Wate	,			Helen	Colbe	,		
Maryland	should be file and Mental H is marked o aumatic eve		19a. Informant's Name/Relationship		19b. Mailir	g Address (Street	and Number or Ru	ural Route Numbe	r, City or Town, State, Z.	ip Code)	
	ind 2 fealth im 27		Diane Waters/	wife	Uppe	Sherbo r Marlb	rn Lane oro, MI	20772	2		
Baltimore,	. 0		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	☐ Removal from State		atory or other plac		Date 7 / 1 1	20c. Location - City o		
altin	permit. Page Department Important: It any injury or		4 ☐ Donation 5 ☐ Other (Spa		Resurrec			ndaes &	Clinton, Edwards	MD	
Ä	Depar Impo any ir		· Januse	9 dun				_	Suitland		
			23a. Part 1. Phter the disease, or co shock, or heart failure. List onl	omplications that caused y one cause on each line	the death. Do not ente	r the mode of dyin	g, such as cardiad	or respiratory an	rest,	Approximate Interval Between	
	Physician/ Medical	8	Immediate Cause (Final disease or condition resulting in death)	_a metas	static S	fuamoi	is cell a	Calcin	Ma	Onset and Death	
-	Examiner		and a second sec	Due to (or as	a consequence of):						
		iner	if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence of):						
	cuted ind transit	Examiner	Cause (Disease or linjury that initiated events	c		·-·					
_	Attending Physician: The law requires that the death certificate be executed ar death. sr death. ector. After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	dical E	resulting in death) Last	Due to (or as	a consequence of):						
3760	ficate g phys	Nedi		d							
Box 687	attending p	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome		Ectopic pregnanc	.v		23d. Date of de	elivery	
Bo	e deat the at hed fo	Physician/Me	1 Yes 2 No	4 ☐ Pregnant a 9 ☐ Unknown		Other (specify)			Month	Day Year	
P.O.	that the deaned by the and detached to	by Ph	Part II. Other significant conditions	contributing to death b	ut not resulting in the ur	nderlying cause giv	en in Part I.	23e. Did to	bacco use contribute to	the cause of death?	
ds,	requires to been signal should be	ed b							☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown		
cor	law rec has ber ge 2 sho	Completed						24a. Was a	an 24b. Were au	topsy findings available completion of cause of	
Re	The la							perfo	rmed? _ death?	s 2 4No	
/ital	ysician; The is certificate director, pag	m	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:		Othe	ace of Death (Che				
of/	g Physer this neral di	e: To	27. Man of Death	28a. Date of injur		3 □ DOA 28c. Injury	4 □ Nursing F at	1	dence 6 Other (Spectors)	cify)	
ion	eath. or; After the funer	lica	1 Natural 5 ☐ Pending 2 ☐ Accident Investigat 3 ☐ Suicide 6 ☐ Could not		(; Year) injury	M 1 □	? Yes 2 🗌 No				
Division of Vital Records,	or Att after d Direct in by i	Certificate:	3 Suicide 6 Could not 4 Homicide determine		ry - At home, farm, stre . (Specify)	et, factory, office		28f. Location (S City or Tow	Street and Number or Ru rn, State)	ıral Route Number,	
Ω	Hospital or Atten 24 hours after deat Funeral Director: sted filled in by the	ical	29a. Certifier 1 Certifying Pt	ysician: To the best of	my knowledge, death of	ccured at the time.	date and place, a	and due to the cau	use(s) and manner as st	ated.	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral	Medical	(Check 2 \(\subseteq \text{Medical Exa} \)	miner: On the basis of exurse Practioner: To the I	amination and/or investi	gation, in my opinio	n, death occurred	at the time, date a	nd place, and due to the	cause(s) and manner stated.	
	5 4 4 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5	2	29b. Signature and title of certifier			29c. License			29d. Date signed (Mont	h, Day, Year)	
			30. Name and address of person who	M MY	ooth (Item 2021) # =		2121		9/29	2011	
	61		BOZ TRAN.	nn 750	? SURRA	TIS RO	OAD .C.	INTO	V PAD	20735	
	State	-	11. Date filed (Month Day, Year)	32. Resistra	r's Signature				, / //		
DHM	Registra 1H 17 Rev 7/200		OCT 1 3	2011 Sene	a B. A.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registral Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 4 Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death 232 10th Street Pasadena, MD Anne Arundel Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 8. Date of Birth **Funeral** 24 Hrs. 9. Birthplace (State or Foreign 1 🗆 M 2 🔀 F Days Hours Min Oct. 5 Months Director 220-36-5665 70 1941 Maryland Yrs Usual Residence of Decedent 28a-f show 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director MD Anne Arundel Pasadena 1X Yes 2 ☐ No 10e. Street and Number 23a or 10f. Zip Code 10g. Citizen of What Country? Funeral 232 10th Street 21122 S. A. items ; 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. 1 X Never Married 2 Married ò þ Baltimore, Maryland 21215-0036 🗌 Yes 2 🔀 No If Yes, Give Year or Dates 1 Yes 2 No Specify White "natural", Snecify. Completed 3 Widowed 4 Divorced marked other than "natur imatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Factory Worker Mary Sue Candies Mental Hygier Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ၉ Floyd Hill Whorton Fannie May (Calhoun) Whorton Health and Nitem 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles L. Wharton Son 232 10th Street, Pasadena, MD 21122 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ō Important: If it any injury or c XBurial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) Glendale Cemetery 10/08/2011 Flintstone, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Hafer Funeral Service, fm 1302 National Hwy., LaVale, MD 23a. Par 1. Enter the dis a e, or complications that aus dithe death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one in use on each line. Approximate Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physici Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year Unknown signed by the a Id be detached f 1 ☐ Yes 2 ¥ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should ! 2 No 3 □ Probably 4 □ Unknown 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of page 2 performe death? 2 🗌 No Yes Yes 2 1 funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home \(5 \) Residence \(6 \sum \) Other (Specify) 1 🗌 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 Yes 2 No Accident Investigation completed filled in by the 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \square Homicide determined 24 hours Medical 29a. Certifier 🗫 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I only one) the 29b. Signature and title of certifie 29c. License numbe 2 Date signed (Month, Day, Year,

State Registrar 30. Nar

31. Date filed (Month Day, Year)

nd address of person who completed cause of death (Item 23a) (T

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Forest 1120 PM Eugene 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore VA Medical Baltmore N/A 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 213 28 1315 1 XM 2 F 79 Hours West Virginia 06713/1932 **Director** Usual Residence of Decedent 28a-f show 10b County with the Maryland notified at 10a. State 10c. City, Town or Location Director 10d, Inside City Limits N/A Maryland Baltimore 1 XYes 2 ☐ No ŏ 10e. Street and Number 10f. Zip Code er than "natural", or items 23a or the Medical Examiner must be r 10g, Citizen of What Country? Funeral 4108 Orchard Avenue 21225 U.S. death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces' þ 1 Never Married 2 XMarried 1 X Yes 2 No 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Year or Dates. Korean Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Bethlehem Steel Outside Machinist permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event; i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Arlie Alt May Sarah Turley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Forest Alt Jr. / Son Glen Burnie, Maryland 21060 1020 Bell Avenue 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Meadowridge Mem. Park 10/10/2011 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the diseases complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph_sician/ disease or condition resulting in death) anoxic brain injury 1 Day Medical Examiner aspiration pneumonia 4 Days Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the burial-transit that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be exec resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) Pregnant at time of death Month Day Year Yes 2 No 9 Unknown Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 No eral Director: After this certificate I filled in by the funeral director, page 1 ☐ Yes 2 🗹 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) မြ 1 Minpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of 29c. License number 1003131566 October 6,2011 9 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Greene Street Baltimore MD 21201 NORA T. OliVER 10

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year) OCT 1 4 2011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ec Medical Facility Name (if not institution, give Examiner 4b. City, Town, or Location of Death 4c. County of Death FMORE Me MUR Social Security Numbe If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland **Funeral** 7. Age (In vrs. last birthday 8 Date of Birth 1 X M 2 🗆 F Months Hours Min. 220 14 1867 12/16/1924 86 Director Usual Residence of Decedent shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. iant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director item 27 is marked other than "natural", or items 23a or 28a-f s other traumatic event, the Medical Examiner must be notified Maryland N/A Baltimore 3 4 1 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral U.S. 610 Annabel Avenue 21225 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married X Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. WW II 1 ☐ Yes 2 X No Specify White Completed 3 XWidowed 4 Divorced Specify. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Elementary/Seconday (0-12) 12th life. DO NOT use retired) College (1-4 or 5+) Maintenance Brewery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Louis Bartolomeo Julia Rowland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna Bartolomeo / Daughter 402 North Bend Road Baltimore, Maryland 21229 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 T Cremation 3 Removal from State 10/12/2011 4 Donation 5 Other (Specify) Bayview Crematory Baltimore, Maryland Signature of Funeral Service License 22. Name and Address of Facility Gonce Funeral Service, P.A. 6 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, our omplications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. nterval Between Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that in its tead or the cause). Due to (or as a consequence of) sician and bunial-transit Exami Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Pregnant at time of death the Unknown ed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signe 1 be o by Records, Completed 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown should Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy certificate 2 **X** No 1 ☐ Yes 2 ☐ No Yes Division of Vital 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) examiner? 1 Tes 2 X No Other: ၉ 1 N Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: After t 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work To the Hospital or Attendion within 24 hours after death. To the Funeral Director: A 1 Tes 2 🗆 No Accident Investigation ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatur title of certifie 30. Name and address of person who completed cause of death tem 23a) (Type, Print) meng WAR 10 32. Registrar's S Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2 1 | State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar Certificate o	f Death	Reg.	No.		
Physic Medical Exam		Decedent's Name (First, Middle,Last)		2. Date of Death	Day Year	3. Time of Death 1550 hrs	
)	me	David Beyer 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deat	October 10, 2011			
		St. Agnes Hospital	Baltimore	3.1	40. County of Death		
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hr	—		hplace (State or	
Director	l	212-19-0221 XXM 2 F 32 Yrs	Months Days Hours Min	Sep.2,	2,1979 Maryland		
Þ	1	Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Local			1		
_ &						10d. Inside City Limits 1 Yes XXNo	
ryland a-f sho	흉	MD Baltimore Reiste	rstown I 10f. Zip Code	I10a	. Citizen of What Coun		
he Ma 1 or 28 iffed 1	Director	12324 Bonmot Place	21136	7.09.		uy:	
death with the Maryland or items 23a or 28a-f sho must be notified at once	퍨	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was	as Decedent of Hispanic Origin? (S		U.S.A.	can Indian, Black,	
P 2 2	Funeral	1 Yes XX No	o Rican, etc.)	White, etc.			
0036 within 72 hours after giene. ner than "natural", c	<u>名</u>	3 Widowed 4 Divorced of Specify Only highest grade completed) 16a Deceder 15. Decedent's Education (Specify only highest grade completed) 16a Deceder	Yes 2 No specify:		Specify: Wh:		
2 hour	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	nt's Usual Occupation (Give kind of nost of working life. DO NOT use re		6b. Kind of Business/Ir	ndustry	
5-0036 led within 72 hou Hygiene. other than "nat the Medical Exa	현		rpenter	Constru		ction	
5-0 led w Hygie		17. Father's Name (First, Middle, Last)		e (First, Middle, Mai			
21215-003 uld be filed withi Mental Hygiene, marked other ti	Be	William P. Beyer, Sr. 19a. Informant's Name/Relationship (Type, Print) Fathor 19b. Mailin	Nanc	Nancy Lee Dougans			
MD 21215-0036 of 2 should be filed within 7 and Mental Hygiene. In 27 is marked other than numatic event, the Medical	욘		g Address (Street and Number or				
C 65 9 7		20a. Method of Disposition 20b. Place of Dispos	4 Bonmot Place sition (Name of cemetery,		Oc. Location - City or		
nor ages l at: if other		1 X Burial 2 Cremation 3 Removal from State crematory or ot	ts Cemetery 10	/14/11	Reisters	town. MD	
Baltimore, permit. Pages I as Department of He. Important: If ite			Name and Address of Facility EC				
E P P		Jacker / Munio 11	605 Reistersto	own Rd. O	wings Mil	11s,MD2111	
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line.	he mode of dying, such as cardiac	or respiratory arrest,	shock, or heart	Approximate Interval Between Onset and	
Examiner		Immediate Cause (Final disease or condition resulting in death)	on and Cocaine U	se		Death	
		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.					
	ner	if any, leading to immediate Due to (or as a consequence of):					
If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):							
executed an and al - transi		d					
	Medical	■ AMENDED 23a,pt.II,27,2	28a-f,per me,g92	0 10-18-1	l sm		
8760, ificate be ug physicials the buria		IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy	tal death 3 Ectopic pregna		23d. Date of delivery Month Da	ay Year	
Box 68 death certifing the attending	Physician/	past 12 months?	tal death 3Ectopic pregna her (Specify)	and y	MOUNT DE	iy real	
Bc he dea y the a	hys	1 Yes 2 No 9 Unknown 9 Unknown					
P.O.	þ	Part II. Other significant conditions contributing to death but not resulting in the u			cco use contribute to the No 3 Proba		
ds, equire een sig	Completed	Cardiomegaly with biventricular dila	itation	24a. Was an 24b. Were autopsy find			
COF law r has b	ם		·	autopsy performe	prior to co	mpletion of cause of	
tal Recian: The		25. Was case referred to medical	26 Place of Parth (Charle	1 ✓ Yes 2		2 No	
/ita	Be	examiner? 1 ✓ Yes 2 No Hospital: 1 ✓ Inpatient 2 ER/Outpatient	26.Place of Death (Check 3 DOA Other Nursin		sidence 6 Other:		
of ng Ph.	٩ E	27. Manner of Death 28a. Date of Injury (Month, Day Year)		28d. Describe how			
ion ttendii leath. ttor: /	atio	Pending fd 10-9-11 fd 2:00		unknown			
Division of Vital Records, tal or Attending Physician: The law require rs after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be	Certification:	3 Suicide 6 X Could not be 28e. Place of Injury - At home, farm, stree		28f. Location (Street or Town, State	et and Number or Rura 2804 Hisd	al Route Number, City	
Baltimore, rid.							
To the Hospital within 24 hours To the Funeral completely filled	Medical	Table Continued 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)					
T wij	Me	and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)					
		O.C.M.E. October 11, 2011					
4	30. Name and address of person who completed cause of death (Item 23a)						
7			. Baltimore Street, Baltimo	re, MD 21223			
St Regist		31. Date filed (Month, Day, Year) OCT 1 4 2011 A Acade					
	_						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Berthiner Butler 3:00 October 2011 Medical 4b. City, Town, or Location of Death Baltimore 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner 4311 Greenhill Avenue 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs 8. Date of Birth **Funeral** Min. 1 □ M 2 🗓 Months Days Hours 3410-1923ar) 217-26-0094 88 Director Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10b. County 10a. State 10c. City, Town or Location with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 XYes 2 No Baltimore n/a MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21206 USA 4311 Greenhill Avenue death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status permit. Page 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 is marked other traumary or other traumary. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc þ 1 Never Married 2 Married Yes 2 😾 No If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: Specify: African-American ted 3 XWidowed 4 ☐ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Complet Elementary/Seconday (0-12) College (1-4 or 5+) Damestic Self Employed 8thBe 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Nece Parker Zelma Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4311 Greenhill Avenue, Baltimore, MD 21206 Verna Larry/Daughter 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) ■ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 10-17-2011 Brooklyn, MD 22. Name and Address of Facility Wile Fineral Home P.A. of Balto. Co. 9200 Liberty Road, Randallstown, MD 21133 Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one education use on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Herme disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Pregnant at time of death 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed has 1 ☐ Yes 2 ☐ No After this certificate eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home Residence 6 Other (Specify) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 \square Homicide determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and fitle of certifie 29c. License number 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4105. MD21200 CRNP 701 N. Lew 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

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	Box 68760
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	of Vital
	ision c

			State of Maryland / Dep	artment of Health and N									
			Registrar 1. Decedent's Name (First, Middle, Last)	rtificate of Death	Reg.								
	Physici: Medi		Kathy Lynn Bond		OCTOBER	Day Year 3. Time of Death							
	Exami		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death							
	<i>J</i>	М	Shady Grove Adventist Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Rockville		Montgomery							
	Funeral Director		216-64-3566 1 M 2 X F 56 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Sept 25,	9. Birthplace (State or Foreign Country) 1955 Washington, DC							
	land show d at	٦	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L.	ocation		10d. Inside City Limits							
	Maryla 28a-f etified	rect	MD Montgomery Damascus			1 ☐ Yes 2 X No							
	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Funeral Director	10e. Street and Number 1 Valley Park Court	10f. Zip Code 20872	10g US	. Citizen of What Country? A							
	items	Fun	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian,							
36	s after des ral", or ite Examiner	Black, White, etc. Specify: White											
21215-0036	2 hours af "natural", adical Exa												
215	in 72 l e. nan "r Med	Completed by	(Specify only highest grade completed) (Give	15. Decedent's Education (Specify only highest grade completed) Flementary(Seconday (0.12) College (1.4 or 5.) Ife. DO NOT use retired) Ife. DO NOT use retired)									
21	d with lygien ther th	Be Co	1 Homer	maker		wn Home							
Maryland	oe file antal H ked of c ever	To B	17. Father's Name (First, Middle, Last)		e (First, Middle, Maid	· · · · · · · · · · · · · · · · · · ·							
ary.	nould but Me in mark		Charles Peyton Bond 19a. Informant's Name/Relationship (Type, Print) 10b. Mail	ing Address (Street and Number or Rura	May Burns								
	d 2 shall all all all all all all all all all		Tob. Wall	lley Park Ct. Dama									
ore	e 1 an If item or oth		20a. Method of Disposition 1 ☐ Burial 2 ▼ Cremation 3 ☐ Removal from State 20b. Place of Disposerery, cre	matory or other place)		c. Location - City or Town, State							
Baltimore,	permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natul any injury or other traumatic event, the Medical once.		4 □ Donation 5 □ Other (Specify) Final Jou	urney Crematory 10		oodbine, MD							
Ba	permi Depar Impo any ir		21. Signature of Funeral Service Licensee Live J Healt Mo1251 Be	2. Name and Address of Facility ping Home Crematio everly L. Heckrott	n Service e, P.A. C	P.O. Box 784 larksville, MD 21029							
	Di		23a. Part 1. Enter the divease, or complications that caused the death. Do not emshock, or heart fature. List only one cause on each line.	er the mode of dying, such as cardiac of	or respiratory arrest,	Approximate Interval Between Onset and Death							
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9289	rtificat ing ph e as th	Mec	IF FEMALE:										
Вох 6	eath certificate t attending physi I for use as the b	ian/	23b. Was decedent pregnant in the past 12 months?			23d. Date of delivery Month Day Year							
). B	es that the decigned by the a	Physician/Med	1 ☐ Yes 2 No 4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown	☐ Other (specify)		Worth Bay real							
P.O.	s that t gned b		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?							
rds,	require been sig	ted	COPD, recent stewned use		1 Yes	2 No 3 Probably 4 Unknown							
oce	The law not attent the law not attent at the	Completed by			24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?							
Ě	sician: The certificate I rector, page		25. Was case referred to medical	00 Plant of Partly (0)	1 Yes 2								
Vita	ysician: is certific director,	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	26. Place of Death (Check		e 6 ☐ Other (Specify)							
of	ding Phy h. After thi funeral		27. Manner of Death 1 Natural 5 Pending 28a. Date of injury (Month, Day, Year) 28b. Time o injury	,	28d. Describe how in								
ion	uttendii death. stor: A: / the fu	Certificate:	2 Accident Investigation	M 1 Tyes 2 No									
Division of Vital Records,	al or Atten s after deat I Director: d in by the		4 Homicide determined determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)							
	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending phy completed filled in by the funeral director, page 2 should be detached for use as the	Medical	29a. Certifier (Check 2 Medical Examiner: On the best of my knowledge, death	tigation, in my opinion, death occurred at	the time, date and pla	ace, and due to the cause(s) and manner stated.							
	To the within 2 To the I complet		only one) 3 Certifying Nurse Practioner: To the best of my knowledge, 29b. Signature and title of certifier	death occurred at the time, date and place 29c. License number	e, and due to the caus	se(s) and manner as stated. Date signed (Month, Day, Year)							
0	- > - 0		Ale Schoole MP		00	CAVENO 2011							
			30. Name and address of person who completed cause of death (Item 23a) (Type, I AVAN S CHANALES ISLASSIFIED SHA	by GROVE RD	ROCKULL	E MO 207575							
	Stat Registra	_	Ot Date Glad (Markly Day Voor)	NES-P									
	registra	'	VOI I - LUIT CERSON G. LOW	All and									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 Certificate of Death Mame (First Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Seasons Hospice at Northwest Hospital Center Randallstown Baltimore Social Security Number 8. Date of Birth (Month, Day, June 17, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Virginia **Funeral** 7. Age (In yrs. last birthday) 1 M 2 M F Days Hours 79 **Director** 223-36-2852 Usual Residence of Decedent 28a-f shov 10a. State 10b. County with the Maryland Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limit Director 1 Yes 2 No MD Baltimore Gwynn Oak 10e. Street and Numbe ō 10f. Zip Code 10a. Citizen of What Country? Funeral items 23a 2121 Windsor Garden Lane Apt. C 21207 USA permit. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cyban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ō þ 1 Never Married 2 Married ☐ Yes Yes, Give Baltimore, Maryland 21215-0036 2 No 'natural", 1 Yes Specify Specify: Black Completed 3 Widowed 4 Divorced Year or Dates Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) than Elementary/Seconday (0-12) 12th Grade College (1-4 or 5+) University of Maryland Hosp. Nurse's Assistant other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mentat F is marked of Charles McDonald, Sr. Alma Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Department of Health ar Important: If item 27 is any injury or other trau once. Celinda V. Randall - Daughter 2121 Windsor Garden Lane Gwynn Oak, MD. 21207 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗹 Burial 2 🗆 Cremation 3 🗆 Removal from State Druid Ridge Cemetery 10/11/2011 Pikesville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature Juneral Service Insee 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Road Baltimore, MD. 21215 23a. Part 1. E ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock. heart failure. List only one cause on each line Interval Between Immediate Gause (Final disease or condition resulting is death) Onset and Death Ph_sician/ Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause Enter Indestrying Examine Due to (or as a consequence of): Cause (Disease or iinjury ng physician and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Pregnant at time of death been signed by the a should be detached to 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy certificate Yes 24 Hospital or Attending Physician: funeral director, 25. Was case referred to ical Be 26. Place of Death (Check only one) examiner? 10 Hospital To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director; After this 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 27. Manne f Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c, Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 5 Pending atural Accident Investigation filled in by the Could not be determined Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and ho completed cause of death (iter

State

Registrar

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		1- For State Registrar		Ċer	tificate of	Death		R	eg. No.	
Physici		Decedent's Name (First, Middle	,Last)					Date of Dea Month	Day Vear	3. Time of Death 1729 hrs
Medical Exam	iner	Antonio Blackwe 4a. Facility Name (if not institution	2]]	umb or)		b. City, Town, or	r Location of		er 28, 2011	
		Johns Hopkins Hospita		umber)	["	Baltimore	Location of	Death		
Funeral			6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Yea	ar If Under	24Hrs. 8. Date of Bi	N/A rth(MM/DD/YYYY) 9. E	Birthplace (State or
Director			1 ∑ M 2□F	26	Yrs.	Months Day	s Hours	Min.	1Fore	eign CountryMaryland
		216-08-1724 Usual Residence of Decedent	UA_IWI ZF		- 113.			04/25	0/1905	Marytanu
any		10a. State 10b. County		10c. City,	Town or Location	on				10d. Inside City Limits
ryland a-f show	5	Maryland N/A		Balt	imore					1 X Yes 2 No
Aaryla 28a-f 1 at o	ect	10e. Street and Number				10f. Zip Code			l0g. Citizen of What Co	ountry?
with the Maryland 18 23a or 28a-f sho e notified at once.	Funeral Director	2631 E. Biddle S	Street			21213			USA	
h with	era	11. Marital Status	12. Was De	cedent Ever in U.				n? (Specify Yes or No Puerto Rican, etc.)	- 14. Race - Ame White, etc.	erican Indian, Black,
r deat or ite	Fu	1 X Never Married 2 Mar	1 Yes	2 X No					specify: Bla	.ck
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. rked other than "natural", or items 23a or 28a-f aherent, the Medical Examiner must be notified at once	by	3 Widowed 4 Divol	rced If Yes, Give Yes or Dates:			Yes 2 X No		nd of work done	Specify: 16b. Kind of Busines	
2 hour "nath	ted	Elementary/Secondary (0-12)	College (st of working life			Tob. Yang of Basines	or in educity
0036 within 7: iene. er than	nple	9th grade			Dietar	y Techn	ician		Stella M	aris
5-0036 led within 72 hours tygiene. other than "natur the Medical Exami	Completed	17. Father's Name (First, Middle, L	ast)		Dictai	y recini	18.Mother's	Name (First, Middle,		
21; be fil ntal F	Be	Timothy R. Blac	kwell				Gayo	or O. Lyde		
imore, MD 21215-0036 Pages I and 2 should be filed within 7 ment of Health and Mental Hygiene. fant: If item 27 is marked other than or other traumatic event, the Medica	ဥ	19a. Informant's Name/Relationshi				•			mber, City or Town, Sta	
		Gayer O. Dantzl 20a. Method of Disposition	er/Mothe	r		astmont tion (Name of ce		<u>le Baltimor</u>	ce, MD 21213	
Baltimore, Normit. Pages 1 and 2 Department of Health Important: If item 2 Injury or other frauming or		1 X Burial 2 Cremation			rematory or oth	er place)				
tim Pag ment tant:		4 Donation 5 Other Spe		Oak	lawn Ce	metery		10/06/201	Baltimore	,MD
Baltimo permit. Page Department o Important:		21. Signature of Funeral Service L	13							
Physician		23a. Part I. Enter the disease, or c	omplications that of						ce, MD 21206 rest, shock, or heart	Approximate Interval
Medical		failure. List only one cause of		unshot Woun	ds					Between Onset and Death
žxaminer		Immediate Cause (Final disease or condition resulting in death)	_	a consequence of						
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	Ē	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a	a consequence of	7):					
ī, ī	Examiner	(Disease or injury maximitiated events resulting in death) Last	Due to (or as a	a consequence of	·):					
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), be ex sician urial	Medical	UNPENDED	AMENDED							_
760, ficate be g physicist the buri		IF FEMALE: 23b. Was decedent pregnant in the		outcome of pregr		al doath 3	Ectopic p	pregnancy	23d. Date of delive Month	ery Day Year
Box 687 e death certifi the attending	ia i	past 12 months?	LIVE	nant at time of dea	-45	al death 3 ner (Specify)		pregnancy	Moral	buy rou.
BO) e deatl the att	Physician	1 Yes 2 No 9 Unkn	9 Unkn	own						
	by P	Part II. Other significant condition	ns contributing to	o death but not re	esulting in the ur	nderlying cause	given in Part		obacco use contribute	
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the stafer death. To Director: After this certificate has been signed by led in by the funeral director, page 2 should be detained in by the funeral director, page 2 should be detained.	힣							— <u> </u>		obably 4 Unknown
Ord w req as bee	틞							24a. Was		autopsy findings available completion of cause of
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Signature After After rector by the	Cat	2 Accident Investi	gation 28e Plan	ce of Injury - At ho	ome, farm, stree				Street and Number or F	Rural Route Number, City
Division ppital or Attenctours after death	Certification:	3 Suicide 6 Could 4 ✔ Homicide	not be	Local Stree				or Town, S 1400 Block o	State) f E. Fayette Street, I	Baltimore, MD
Hospi 24 hou Funer rely fil	•	29a. Certifier 1 Certifying Phy	siclan: To the be	st of my knowledg	ge, death occurr	ed at the time, d	ate and plac	e, and due to the cau	se(s) and manner as st	ated.
Division To the Hospital or Attendin within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	one) 2 Medical Exam	iner: On the basis and manner s	of examination ar	nd/or investigati	on, in my opinior	n, death occu	urred at the time, date	and place, and due to	the cause(s)
H 3 H 3	Me	29b. Signature and title of certifier	. /			29c. Licens		0045	29d. Date signed (M	
		Thoday 14	. Third	Tay in	ec)	O.C.	M.E.	OCME	September 29,	2011
mV	İ	30. Name and address of person w		,	•	00.144 B.141	nor- Ct-	at Daltimore 14	D 24222	
		Theodore M. King, Jr.,				OU VV. Baltir	nore Stre	et, Baltimore, M	U 21223	
St Regis		31. Date filed (Month, Day, Year) OCT 1 4 20		egistrar's Signatu	barke					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes 32720 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 9:35 DELORES. BROWN E. 10 201 Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death UNIVERSITY OF MARYLAND BALTIMORE N/A 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Sept. 1 9. Birthplace (State or Foreign Country) Maryland Age (In yrs. last birthday) **Funeral** 1 M 2 F Months Director 219-28-7799 78 1933 Usual Residence of Decedent 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits N/A MD 1 Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 702 Dolphin Street Apt. 1 21217 USA 12. Was Decedent Eyer in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, rmed Forces? Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify 3 Widowed 4 Divorced Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) State of Maryland Administrative Assistant 12th Grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Unknown Mildred Young 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3512 Royston Avenue Baltimore, Maryland 21206 Nathaniel Brunson -Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Green Mount Cemetery 10/11/2011 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland . Signature of Funeral Service Licensee 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Road Baltimore, MD. 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition resulting in death) Onset and Death Physiciani CORONARY ARTERLY Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or linjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
 Funeral Director: After this certificate has been signed by the attending physician and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnan 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Day s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown After this certificate has been funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 2 No 1 Yes 1 Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? 1 Yes Other: ၀ 2 No 1 Inpatient 2 ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Yes 2 🔲 No Investigation completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the I within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Sjgnatur and title of 29c. License number 29d. Date signed (Month, Day, Year) M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SOUTH GREENE BAUTIMORE MD EUDKI STREET 21201 31. Date filed (Month 2. Registrar's Sign State 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 20 | 3272 | State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Certificat	e of D	Death			Reg.	No.	
Physici		Decedent's Name (First, Middle,Last)	2. Date of [Month					e of Death	ay Year	3. Time of Death
Medical Exam	ıner	Joe Nathan Bowden.Jr.	O					ober 6, 2	011	2015 hrs
		4a. Facility Name (if not institution, give street and number) 3700 Greenspring Avenue Apt 802			City, Town, o Baltimore	r Location	of Death		4c. County of Death	
F			rs, last birthda			a. 1611ada	24U To D	to of District		
Funeral Director		214-62-6649 ₁ K _M ₂ F 56	s, last birthoa	-	If Under 1 Ye				им/DD/YYYY 9. Віг 9 , 1 9 5 ^{Foreig} Со	
any		Usual Residence of Decedent 10a. State 10b. County 10c. C	City, Town or	Location						10d. Inside City Limits
		Maryland N/A	Balti							1 XYes 2 No
ryland a-f show t once.	ţ	10e. Street and Number	Dare		Of, Zip Code			140=	Citizen of What Cou	
hours after death with the Maryland "natural", nr items 23a or 28a-f sho Examiner must be notified at once.	Director		.802	,	212	211		-	USA	ntry?
th wil	era	11. Marital Status 12. Was Decedent Ever in Armed Forces?	1 U.S. 13	3. Was D	ecedent of Hi	ispanic Orig	gin? (Specify Y , Puerto Rican,	es or No- etc.)	14. Race - Ameri White, etc.	can Indian, Black,
r dea	Fune	1 Yes 2 X No		_				 ,		71.
s afte	Š	3 Wildowed 4 Divorced If Yes, Give Yaar or Dates:			s 2X No					lack
hour Fra	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)		ing most	of working life	etion (Give i	kind of work do use retired)	ne 16	b. Kind of Business/l	ndustry
5-0036 ed within 72 hor tygiene. nther than "na	Be	1 year	Une	empl	oyed					
5-00 lled with Hygien the Me	Ö	17. Father's Name (First, Middle, Last)				18 Mother	's Name (First,	Middle Maid	len Surname)	
	Be	Joe Nathan Bowden, Sr.					sy Dav		ion daniento,	
nore, MD 21216 ages I and 2 should be fill nt of Health and Mental H it: If item 27 is marked other traumatic event, it	ToE	19a. Informant's Name/Relationship (Type, Print)	19b. N	Mailing Ad	dress (Stre				, City or Town, State	, Zip Code)
MD 2 sho h and 27 is		Terry Stanley/ Brother							all,MD 2	
2 d B d			b. Place of D	isposition	(Name of ce	emetery,	Date	20	c. Location - City or	Town, State
TOT Pages ent of ent: Id		1 Burial 2 Cremation 3 Removal from State	crematory odlav			rv	10/13	3 / 1 1 W	oodlawn.	Maryland
Baltimore, permit. Pages 1 at Department of Het Important: If ite injury nr other tr		4 Donation 5 Other Specify: WC 21. Signature of Funeral Service Licensee								eral Home
		Level Hours		5240) Paic	tore	town F	in-na Id Ba	rris rui ltimore	MD 21215
Physician	-	23a. Papt 1. Enter the disease, or complications that caused the dea failure. List only one cause on each line.	ath, Do not er	nter the m	node of dying	, such as ca	ardiac or respire	atory arrest,	shock, or heart	Approximate Interval
/Medical		Immediate Cause (Final disease a Narcotic (Morp	hine)	Into	ki cati	on				Between Onset and Death
£xaminer		or condition resulting in death) Due to (or as a consequence								
	_	Sequentially list conditions, b.								
	ine	if any, leading to immediate Due to (or as a consequence cause. Enter Underlying Cause	∌ Of):							
=	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence	e of):							
760, cate be executed physician and he burial - transi		d.	1 00							
760, cate be execut physician and he burial - tra	Medica	▼ UNPENDED	ted,23	a,2/	,28a-f	,per	me, g920	10-2	7-11 sm	
760, ficate be g physici the buri	Š	IF FEMALE: 23b. Was decedent pregnant in the	egnancy	_					23d. Date of delivery	
ox 68° ath certificant attending or use as 1	sician/	past 12 months?	death 5	Fetal d		Ectopic	pregnancy	- 1	Month E	ay Year
Box 68 death certif the attending of for use as	ysi	1 Yes 2 No 9 Unknown 9 Unknown	5	Other	(Specify)					
. 2 . 2	Phy	Part II. Other significant conditions contributing to death but no	t resulting in	the unde	rlying cause	given in Par	rt I. 23	e. Did tobac	co use contribute to	the cause of death?
P.O.	d b						1	Yes 2	No 3 Prob	ably 4 Unknown
requi	Completed						24	a. Was an		topsy findings available
e law te has	립						— I.	autopsy performed	? death?	ompletion of cause of
tal Re		25. Was case referred to medical			26 Place	of Death /	Check only one		No 1 ✔ Ye	s 2 No
of Vital Records, ig Physician: The law require the things certificate has been sineral director, page 2 should be	Be	examiner? Hospital: 1 Innationt 3	ER/Outpa	tient 3		Other ₄			idence 6 🗸 Other	Scene
of \ & Phy filer the	음	27. Manner of Death No. 1 Inpute 1 2 2 8a. Date of Injury (Month, Day, Yaar)	28b. Time			ry at Work?			injury occurred	
on ath. Ar: A	Ę	Pending fd 10-6-11	fd 8:	10 p	m	Yes 2 🗶	No unkn	own		
Division tal or Attendi rs after death. al Director: /	fig	Accident Investigation 28e Place of Injury - At				ouilding, etc	28f. Lo	cation (Stree	et and Number or Ru	ral Route Number, City
Diversity of filled i	Certification:		ound a	ıt re	siden	ce	#802	Town, State	3700 Green	nspring Ave.
DIVISIOI To the Hospital or Attent within 24 hours after death To the Funeral Director:		29a. Certifier 1 Certifying Physician: To the best of my knowle	edge, death o	occurred a	at the time, da	ate and pla	70.00			ed.
Tu the Ho within 24 } To the Fu	Medical	one) 2 Medical Examiner: On the basis of examination and manner stated.	and/or inves	stigation,	in my opinion	, death occ	curred at the tim	e, date and	place, and due to the	e cause(s)
	Ž	29b. Signature and title of certifier	XA		29c. Licens	e number		29	d. Date signed (Mor	th, Day, Year)
		Cult fler fell	100		O.C.I	M.E.		0	ctober 7, 2011	
	ı	30. Name and address of person who completed cause of death (Ite	,							
<i>X</i> 0		Victor Weedn MD JD Assistant Medical Exam		0 W. B	altimore S	treet, Ba	altimore, MD	21223		
Sta Registi	_	31. Date filed (Month, Day Year), 32. Restrare Signal	iture	1	11					
	_	· TEUITI (FAME)	P. 1		000					
DHMH 17 Rev 1/20	1	OCME	ORIGI	NAL						

1 - For Amend Item 25 State of Maryland / Pagating Health and Mental Hygiene Registrar 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ September Blevins largaret 201 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Anno Burnic Hrunde Date of Birth (Month, Day, **Funeral** 9. Birthplace (State or Foreign 1 M 2 F 220.66.205 MARYLAND Director 28a-f shov Department of Health and Mential Hygiene. Important: fi tems 23a or 28a-f sho Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral U.S.A. 4439 MOUNTAIN RD. 21122 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify 3 ₩idowed 4 Divorced Completed JhITE Blevins, Margaret 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) SERVER KESTAI 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ SWEITZER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4302 BEILEGROVE AD, BROOKLYN PARK MD. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ARUNDE CREMATORY 9-29-11 4 Donation 5 Other (Specify) ODENTON 22. Name and Address of Facility Daugh ERTY FUNE AND HOME ZLOSI MOUNTAINRO, PASADENS, MD. Z1122 Part 1. Enter the cisease, or shock, or heart failure. List on prications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, y one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, bading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last CERTIFICATION APPROVED BY CAL EXAMI Examine Due to (or as a sonsequence of). attending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Dav Year Pregnant at time of death signed by the at d be detached for Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown should Were autopsy findings available prior to completion of cause of 24a. Was an the Hospital or Attending Physician; The law 24 hours after death.

Funeral Director: After this certificate has eted filled in by the funeral director, page 2.5 page 2 autopsy performed? Yes 2 No death? 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 X Yes Other: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated the only one) 3 within To the 29b. Signature and title of co 29d. Date signed (Month, Day, Year) 0327 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 301 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 3 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1- State of Maryland / Department of Health and Mental Hygiene State of Maryland / Department of Health and Mental Hygiene Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Veal **Physician** Bar AM 0930 John 2011 October /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Johns Hopkins Bayview Medical Center **Baltimore** 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F 218-52-3507 Yrs. Director 62 Feb 22. 1949 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Example. 10a, State 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☐ No MD Howard Cooksville 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 2149 Route 97 Funeral 21723 Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 📆 No Specify \$ 3 Widowed 4 X Divorced Specify: White Year or Dates Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Contractor Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ernest Barth, Sr. ည Alice Streaker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. James Barth (Brother) 782 Powhatan Beach Rd., Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crestlawn Mem. Gard. 10/5/2011 | Marriottsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA 23a. Part 1. Enter the disease, or compligations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. PO Box 195 Sykesville, MD 21784 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Brainstem **Physician** /Medical Due to (or as a consequence of) Examiner Intracerebr Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine APPROVED BY MEDICAL EXAMINER The law requires that the death certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of): CERTIFICATION Division of Vital Records, P.O. Box 68760, ding physician Physician/Medical 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 23d. Date of delivery Live birth 2 Fetal death 3 - Ectopic pregnancy for in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) Yes 2 No detached 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ ate has been signated by page 2 should by 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 1/2 2 No certificate 2 □ No 1 Tes or Attending Physician: 25. Was case referred to medical examiner?
1 A Yes director Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence မ 2 R/Outpatient 3 DOA 6 Other (Specify) s after death.

I Director: After this of in by the funeral d this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours aft To the Funeral Dir completely filled in the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chikezie 4940 Eastern Avenue, Baltimore, MD, 21224 31. Date filed (Month, Day, Year) Registrar's Signature State OCT 1 3 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 18 per fh 9919 9-20-11 vt
State of Maryland / Department of Health and Mental Hygiene
1- State Registrar Amend Items 25,27,28a-f per me. 9920,10/07/2011dhb
Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Bel Month Dav Yoar 22: 45 PM Havid September /Medical 2011 4a. Facility Name (If not institution, give street and 4b. City. Town, or Location of Death Examiner 4c. County of Death Johns Hopkins Bayview Medical Center **Baltimore** N/A | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Day Year) | Min. | DEC. | 8 / 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) **Funeral** 9. Birthplace (State or Foreign 1 □XM 2 □ F , 1954 Yrs MARYLAND 213-64-8053 56 Director Usual Residence of Decedent death with the Maryland 10a. State show 10b Counts 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown yinjury or other traumatic event, the Medical Examiner must be notified at once. Director X Yes 2 □ No MD N/A BALTIMORE 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? CLINTON ST. 407 S. Funeral 21224 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Ite Black, White, etc. 1 Never Married 2 Married Yes Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Q Q Specify 3 X Widowed 4 ☐ Divorced Specify: Year or Dates: WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MACHINE OPERATOR 6 ROCKTEN BOX CO. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILLIAM BELL ၉ CAROLINE -N/A Weinbeck 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAVID L. BELL, JR./ SON 3001 VULCAN ROAD, BALTIMORE, MD 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State 4 Donation 5 Other (Specify) BAYVIEW CREMATORY 9/15/11 BALTIMORE, MARYLAND 21. Signature of Funeral Santo Censee Name and Address of Facility
LILLY & ZEILER INC. FUNERAL HO
1901 EASTERN AVENUE, BALTO., MD FUNERAL HOME 21231 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Intracrania 1 Physician Hemorroga Medical / Due to (or as a consequence of): CERTIFICATION APPROVED BY MEDICAL EXAMINER Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence oil or Attending Physician: The law requires that the death certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician Physician/Medical 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 TEctopic pregnancy in the past 12 months? Month Day Year 1 🗌 Yes 5 Other (specify) 2 □ No the 9 Unknown Division of Vital Records, P.O. 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ Preumonia Completed 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 X No 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 NK 1 XInpatient Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 2 ER/Outpatient 3 DOA မ this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Subject fell After 5 Pending investigation 08/20/2011 2 Accident Unknown 1 🗀 Yes 2 X No down set of concrete steps. 24 hours after death Funeral Director: filled in by the 3 🗌 Suicide Could not be determined . Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 407 S. Clinton St. 4 | Homicide Home Baltimore,MD Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 September 13, 2011 Name and address of person who completed cause of death (Item 23a) (Type, Print) Gastor-Murd. M.D 4940 Eastern Avenue, Baltimore, MD, 21224 lomas State 31. Date filed (Month, Day, Year) 3. Registrar's Signature OCT 0 7 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien) For State Registrar Certificate of Death Reg. No. 2. Date of Poath Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death $_{
m Year}11$ Physician/ William Frederick Buchman 3pm Medical 4b, City, Town, or Location of Death Belair 4a. Facility Name #-nct institution, give street and number)
Upper Chesapeake Ac County of Death **Examiner** 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Numbe **Funeral** 220-22-4044 1 XM 2 F Months Days Hours Min. 110008 Y 1925 Mary land **Director** Usual Residence of Decedent or 28a-f show notified at 10b. County 10d. Inside City Limits 10a State 10c City Town or Location Director 1 Yes 2 No MD Harford Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o edical Examiner must be Funeral 21050 USA 3002 Scenic View Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14 Race - American Indian. Armored Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married þ 21215-0036 If Yes, Give 1944-1946
Year or Dates. 1 ☐ Yes 2 🔀 No Specify: Specify:White 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) the Me Elementary/Seconday (0-12) College (1-4 or 5+) Fire Fighter Baltimore and Mental Hygie is marked other Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Vida Hackley William F. Buchman Sr. 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Coda) 3002 Scenic View Drive Forest Hill, MD 21050 19a. Informant's Name/Relationship (Type, Print)
Barbara Buchman/Wife Department of Health ar Important: If item 27 is any injury or other trauonce. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ₺ Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) 10-14-2011 Parkville, MD Parkwood Signature of Funeral Service 22. Name and Address of Facility Ke Schimunek Funeral Home Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph sician/ ardiac disease or condition Medical resulting in death) as a consequence of) **Examiner** Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical 68760 attending p IE FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Year Month Day Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions, contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 1 ☐ Yes 2 ☐ №6 the Hospital or Attending Physician: 25. Was case referred to/medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes/ 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 1 Natural 5 Pending 1 Yes 2 No within 24 hours after death To the Funeral Director: A ☐ Accident☐ Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifie 0054855 2011 of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address State Registrar

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Mecclozes

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 32726 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Verna Elizabeth Carroll October 2011 7:15A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Gilchrist Center Towson Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 7. Age (In yrs. last birthday) Days Min 216-20-3709 88 September 23,1923 Baltimore, Maryland Director 1 🗆 M 2 🗶 F Usual Residence of Decedent i Hygiene. other than "natural", or items 23a or 28a-f show out the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director Maryland Baltimore Parkville 1 Yes 2 X No 10e. Street and Number 10g. Citizen of What Country? 2219 G Lowells Glen Road 21234 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 X No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 🗌 Widowed 4 🗆 Divorced Specify: White Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Insurance Company Claims Dispatcher should be filed with and Mental Hygien 7 is marked other tl 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Anna Belle Chalk Charles R. Carroll 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) mit. Page 1 and 2 st partment of Health a portant: If item 27 is y injury or other trai 9703 Bernard Lewis Court Penry Hall, Maryland 21128 Patricia Costantini (Cousin) 20b. Place of Disposition (Name of cemetery, crematory or other place)

Parkwood Cemetery 20a. Method of Disposition 20c, Location - City or Town, State Date ær 15, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkville, Maryland 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services Parkville
8800 Harford Road Parkville, Maryland 21234 21. Signature of Funeral Service License D 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician C rem disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due o (or as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) in the past 18 months? Ectopic pregnancy Month Day Year Pregnant at time of death been signed by the should be detached 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 nknown To the Hosping. ... within 24 hours after death.

To the Funeral Director. After this certificate has been significant of the funeral director, page 2 should by the funeral director, page 2 should be a should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Hospital Other: ည 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DCA 4 Nursing Home 5 Residence Mapner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate; Natural Accident work? 5 Pending injury Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner. To the best of my Incompage, death occurred at the time, date and plane, and due to 29d. Date signed (Month, Day, Year) 29b. Signature 29c. License number 2 ress of person who completed cause of death (Item 23a) (Type, Print) harter STTONSONMI

State Registrar 31. Date filed (Month, Day

11-07356 Benov M. Chacke Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Marvland / Department of Health and Mental Hygiene

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зепоу м. Спаск		State of Maryland / Department of Health and Mental Hygiene Z U 1- For State Registrar Certificate of Death Reg. No.	3212
Physicia Medical Exami		1. Decedent's Name (First, Middle, Last) 2. Date of Death Anoth Anoth Decedent's Name (First, Middle, Last)	ime of Death 342 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death WMATA Track 1 @ Chain Marker 821 100 Rockville 4c. County of Death Montgomery	<u> </u>
Funeral Director		5. Social Security Number 372–98–9500 6. Sex 17. Age (In yrs. last birthday) 1f Under 1 Year 1f Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace Foreign Country)	
Aaryland 28a-f show any 1 at once.	or	MD Montgomery Gaithersburg	Inside City Limits X Yes 2 No
with the Maryland ns 23a or 28a-f sho be notified at once.	Director	10e. Street and Number 324 Market Street 20878 10g. Citizen of What Country? USA	
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once	by Funeral	11. Marital Status 1 XNever Married 2 Married 3 Widowed 4 Divorced of 15 yes, Give Year or Dates: 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 1 Yes 2 No specify: 1 Yes 2 No specify: 1 Yes 2 No specify: 1 Yes 2 No specify:	
5-0036 lled within 72 h Hygiene. I other than "r the Medical I"	Completed	Elementary/Secondary (0-12) 12 College (1-4 or 5+) 5+ Research Scientist Science 17. Father's Name (First, Middle, Last) Science	1 <u>-</u> ·
MD 21215-0036 12 should be filed within 7 th and Mental Hygiene. 127 is marked other than umartic event, the Medica	To Be C	bolii chacko	Code)
	F 1	Kristina Mathews / Sister 60 Laurentide Brampton, Ontario 20a Method of Disposition	_
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and N Important. If item 27 is n injury or other traumatic.		1 Burial 2 Cremation 3 Removal from State White Chapel Cemetery 10/08/11 Troy, MI	, 0.010
Physician		1501 E. Fort Ave Baltimore MD 21230	proximate Interval
/Medical Examiner			etween Onset and Death
	aminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last UNPENDED AMENDED 23a, 27, 28a-f, per me, g920 10-20-11 sm IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery	
60, ate be executed hysician and e burial - transit	cal Ex	events resulting in death) Last Due to (or as a consequence or): d. MENDED 23a, 27, 28a-f, per me, g920 10-20-11 sm	
certifi nding	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	Year
P.O. es that the igned by t	2	1 Yes 2 ✓ No 3 Probably	
Records The law requicate has been	Completed	24a. Was an autopsy prior to comple death? 1 ✓ Yes 2 No 1 ✓ Yes	findings available etion of cause of
Vital hysician:	O Be	25. Was case referred to medical examiner? 1 Ves 2 No No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 V Other: Scen	ne
┌ ⋕.⋖⋷		. I Z7. Manner of Death I Z80. Date of Injury I Z80. Time of Injury 1 Z80. Injury at Work? I Z80. Describe now injury occurred	train
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifi completely filled in by the funeral director,	l Certification:	29a Centiler 1	
To the within 2 To the Complet	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause and manner stated. 29b. Signature and title of certifien.	
		October 1, 2011	-51 - 44/)
10	7	30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	1
Sta Regist	-		
DHMH 17 Rev 1/20	001	OCME ORIGINAL	

State of Maryland / Department of Health and Mental Hygiene? [] | | Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ George Washington Coakley, Jr. 201 Medical october *i* 0 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Anne Arunde Glen Burnie Social Security Number **Funeral** Date of Birth 9. Birthplace (State or Foreign Country) D.C. 1 **X** M 2 □ F Months 74 02725/1937 Director 217 32 1612 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any ones. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland N/A Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 221 Pontiac Avenue 21225 U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. δ 1 Never Married 2 Married 1 Yes 2 X No If Yes, Give Maryland 27215-0036 1 ☐ Yes 2 🛣 No Specify 3 XWidowed 4 Divorced Completed Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Owner Elementary/Seconday (0-12) College (1-4 or 5+) 10th Auto Bady Repairman Auto Repair Shop Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George W. Coakley, Sr. Elizabeth Sauters 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arlene Klemkowski / Daughter 221 Pontiac Avenue Baltimore, Maryland 21225 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State MD. State Veteran Cem. 10/17/2011 Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 4001 Ritchie Highway 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician. Medical resulting in death) **Examiner** WWER 1565 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Cause (Disease or linjury that initiated events the burial-tran resulting in death) Last Due to (or as a consequence of): led by the attending physician detached for use as the buria Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗀 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Dav Year 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be Completed 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2- No မ Other: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number OCTOBER 10, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1200, NO.LU WITSIM 32. Registrar's 9 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month object Physician/ Medical 4a. Facility Name (if not institution, give street and number) n, or Location of Death **Examiner** 4c. County of Death Hospital balt more HOPKIN Baltimore City OhNS lt 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 421-74-0631 Hours **Director** 1 □ M 2 🕱 F 59 July 14, 1952 Alabama Usual Residence of Decedent show 10a. State 10b. County notified at 10c. City, Town or Location Director 10d. Inside City Limits 28a-f Alabama Macon 1 X Yes 2 No Tuskegee 10e. Street and Number ō 10f. Zip Code ed other than "natural", or items 23a or event, the Medical Examiner must be 10g. Citizen of What Country? Funeral 206 N. Lake Street 36083 United States 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. 3 Divorced Completed Specify: Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than College (1-4 or 5+) Elementary/Secondary (0-12) and Mental Hygiene. is marked other tha Realtor Self Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Roosevelt Crawley Lizzie Mae Collins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Angela Collins / Daughter 926 N. Rosedale St., Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a Department of H Important; If ite Date 20c. Location - City or Town, State 1 D Burial 2 D Cremation 3 E Removal from State injury or Oct 11 10, Mt. Pleasant Ch. Cem. Tuskegee, Alabama onation 5 Other (Specify) of Fune Servi 21. Signat Kirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy., S.E., Glen Burnie, MD 21061 23a. Part 1 Shter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Advanced metastatic colon carcinoma. disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** metabolic acidosis Secrentially flat conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of hepatir failure Cause (Disease or injury that initiated events resulting in death) Last Severe and use as the burial-tra Due to (or as a consequence of) After this certificate has been signed by the attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicial Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed . Were autopsy findings available prior to completion of cause of 24a. Was an director, page 2 autopsy perform death? 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be examiner? 1 Yes 2 No Other: ၉ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) filled in by the funeral Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending work 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 06-2011

000 N. Wolfe St

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PRIYANKKUMAR

1 4 2011

31. Date filed (Month, Day, Year)

P. PATEL, MD

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [32730 For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 9:03 A M Richard McVey Coale <u>October</u> Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Timonium Baltimore Social Security Number If Under 1 Year If Under 24 Hrs **Funeral** Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days (Month, Day, Year) Hours **Director** 218-38-2649
Usual Residence of Decedent 1 🔀 M 2 🗆 F 72 1939 26, Maryland 3a or 28a-f show t be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 ื No Harford Maryland Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral er than "natural", or items 23: the Medical Examiner must 2124 Poteet Road 21050 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1

✓ Yes 2

No Black, White, etc. þ 1 Never Married 2X Married 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Engineering Technician U.S. Government Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Webster Coale Sr. Marian Zora Phillips 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Audrey T. Coale / Wife Department of Health Important: If item 27 any injury or other t 2124 Poteet Road, Forest Hill, MD 21050 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Carmel Cemetery 10-16-11 Bel Air, Maryland 22. Name and Address of Facility McCcmas Funeral Home, P.A. 50 W. Broadway, Bel Air, MD 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition LUNG CANCER Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 【Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 🗌 Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Certificate: To 1 Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 □ Nursing Home 5 □ Residence 6 🗷 Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Tes 2 No Accident Investigation 24 hours after deat Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🖫 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of 29d, Date signed (Month, Day, Year) 2011 erson who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature **State** Registrar

DHMH 17 Rev 06-2011

a.m.

9:03

OCTOBER

COALE

11-07450 Patrick Cush Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 20 | 3273 |

		1- For State Registrar	Ce	rtificate c	of Death		R	eg. No.				
Physici		1. Decedent's Name (First, Middle,L	ast)				2. Date of Dea Month	th	3. Time of Death			
ledical Exam	iner	Patrick Mich	ael Cush				October 5	Day Year 5, 2011	0835 hrs			
		4a. Facility Name (if not institution, g			4b. City, Town,	or Location of De	eath	4c. County of Dea	th			
		717 Druid Park Lake Dri			Baltimore	/A						
Funeral Director		220 62 6150	Sex 7. Age (In yrs. 5.5)						irthplace (State or ign Wash., DC			
, h		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location										
w any												
ryland a-f show	ō		, ,	Dal CIIII					1 Yes 2 No			
Mary 28a-	Director	10e. Street and Number 717 Druid Park	. Lake Drive	Unit	10f. Zip Code		1	0g. Citizen of What Co	untry?			
h the 3a nr		/// Didia lair	Lake Diive	1004	212	217		USA				
h with	Funeral	11. Manital Status	12. Was Decedent Ever in L Armed Forces?		as Decedent of H Yes, specify Cub		(Specify Yes or No	- 14. Race - Ame White, etc.	rican Indian, Black,			
roust	들	1 Never Married 2 Marrie	1X Yes 2 No				sito recan, etc.)	vville, etc.				
after	by I		ed If Yes, Give Year or Dates:	1_	Yes 2X N			Specify:	*			
hours natu	pe	15. Decedent's Education (Specify			nt's Usual Occup nost of working lit			16b. Kind of Business	s/Industry			
36 n 72 ical	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 2 years Unemployed										
5-0036 filed within 7: Hygiene. d other than	шо	47 Fall and Name (First MC) Head	2 years	Unem	Бтолеа	Landau	(5)					
15- filed filed filed		17. Father's Name (First, Middle, Las Gerald Cush	я)		1		ame (First, Middle, I a Raabe	Maiden Surname)				
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	o Be		(Type Print)	10h Mailir				nhor City or Town Sto	to Zin Codo)			
O % 3 : 2	70	19a. Informant's Name/Relationship (Type, Print) Cherie M. Degnan/Sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Informant's Name/Relationship (Type, Print)										
Baltimore, MI cernit. Pages 1 and 2 s Department of Health a Important: If item 27 injury or other traum		20a. Method of Disposition 1 Burial 2 Cremation 3		Place of Dispo crematory or o	sition (Name of c ther place)		Date	20c. Location - City of				
MOFE Pages 1 nent of H int: If i		4 Donation 5 Other Specia	_ r_	enmou	nt Ceme	etery	10/13/11	Baltimo	re,Maryland			
Baltimo permit. Page Department or Important: injury or otl		21. Signature of Funeral Service Lic		22.	Name and Addre	ss of Facility (Chatman-	Harris F	uneral Hom			
E F C E W		Leroy No	ico	5	240 Re:	istersi	own Rd	Baltimor	uneral Home e,MD 21215			
Physician		23a. Part I. Enter the disease, or con failure. List only one cause on		. Do not enter	the mode of dying	g, such as cardia	c or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and			
' /Medical :xaminer			Head Injuries						Death			
·Adminier		or condition resulting in death)	Due to (or as a consequence of	of):								
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اند	Eam	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of	of):								
executed an and al - transit												
ਿਲ ਲੋਕ।	/Medical	X UNPENDED	AMENDED 23a, 27, 2	28a-f,p	er me,g9	21 11-1	6-11 sm					
Box 68760, death certificate be exe he attending physician of for use as the burial -	Me	IF FEMALE:	23c. If yes, outcome of preg	nancy				23d. Date of delive	ry			
		23b. Was decedent pregnant in the past 12 months?	1 Live birth		etal death 3	Ectopic pre	gnancy	Month	Day Year			
Box 68 death certif the attending ed for use as	Si	1 Yes 2 No 9 Unknow	Pregnant at time of de	eath 5 🗌 o	ther (Specify)			Ų.				
he de y the hed for	Physiciar		9 Опкложн			The same of the sa	Loo- Dida		the course of death?			
of Vital Records, P.O. Box 68 ing Physician: The law requires that the death certif After this certificate has been signed by the attending uneral director, page 2 should be detached for use as	Ď	Part II. Other significant conditions	contributing to death but not r	esuiting in the	underlying cause	given in Part I.		bacco use contribute to	obably 4 🗸 Unknown			
quires en sig	E								utopsy findings available			
of Vital Records, ag Physician: The law require ther this certificate has been si meral director, page 2 should b	Completed					·	autop	sy prior to	completion of cause of			
Rec The l	ē						1 Yes	rmed? death? 2 No 1 ✔ \	es 2 No			
ertifi etor,	Bec	25. Was case referred to medical			26.Plac	e of Death (Che	ck only one)					
Vit.	0	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatien	t 3 DOA	Other Nu	rsing Home 5	Residence 6 🗸 Oth	er: Scene			
J Of Jing Ph After t funeral	=	27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of	Injury 28c. Inj	ury at Work?		how injury occurred				
	iĝ.	1 Natural 5 Pending 2 X Accident Investiga	£1 10 5 11	fd 8:00	o am l 1	Yes 2 X No	subject	fell				
Division rate of a strength. It all birectors. A led in by the fulled in b	Ë	3 Suicide 6 Could no	28e Place of Injury - At h			building, etc.	28f. Location (S	Street and Number or R	ural Route Number, City			
Division spital or Attentions after death ser al Director: filled in by the	Certification:	4 Homicide determin	ed (Specify)apartmen	nt buil	ding	rence 5	Baltimo		d Park Lake			
Division of Vita To the Hospital or Attending Physicia within 24 hours after death. To the Funeral Director: After this ce completely filled in by the funeral direc		29a. Certifier 1 Certifying Physic	clan: To the best of my knowled			date and place, a	and due to the caus	se(s) and manner as sta	ited.			
To the Howithin 24 h To the Ful	Medical	one) 2 Medical Examine	er:On the basis of examination a and manner stated.	nd/or investiga	ation, in my opinio	n, death occurre	ed at the time, date	and place, and due to t	he cause(s)			
H S H S	ž	29b. Signature and title of certifier			29c. Licer	se number		29d. Date signed (M	onth, Day, Year)			
۸		1 landonloss	W		0.0	.M.E.		October 5, 2011				
or and	}	30. Name and address of person who	completed cause of death (Item	1 23a)			<u></u>	1				
0.1		Laron Locke MD. Assis	stant Medical Examiner	900 W. B	altimore Stre	et, Baltimore	e, MD 21223					
St	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signa	are park	4							
Regist		OCT 1 4 20°	11 Denewa B.	SUPERIOR								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2011 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Milan Stephen Cerstvik 2011 1:20 a M October Medical 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death 4b. City, Town, or Lo. Frederick 4c, County of Death Frederick **Examiner** North Hampton Manor Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 3/20/1925 Country) NJ 144-01-9708 Director 1**X** M 2 □ F 86 Usual Residence of Decedent ns 23a or 28a-f show must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director MD Frederick Frederick 1 Yes 2 x No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6862 Buckthorn Court 21703 United States tems "natural", or item edical Examiner n 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 0 1 Never Married 2 Married 1 Yes 2 □ No If Yes, Give δ and 2 should be filed within 72 hours after Health and Mental Hygiene. Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify. Specify: 3 Divorced 4 Divorced Completed Year or Dates ed other than "natur event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Government Naval Officer marked other Be 18. Mother's Name (First, Middle, Maiden Surname) Lillian Janco 17. Father's Name (First, Middle, Last) ల Stephen Cerstvik injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mildred H. Cerstvik / Wife 6862 Buckthorn Court, Frederick, MD item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Uniformed Serv. Univ. 10/06/2011 Bethesda, MD 4 ☑ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rapp Funeral & Cremation Svcs. 933 Gist Ave. Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death HEART Immediate Cause (Final Physician/ CONCETTIVE MO UTHS. disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine thany, leading to immedia cause. Enter Underlying Que to for an a nonneouenne offi the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending phase as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months? Day Year Month 4 ☐ Pregnant at time of death 9 ☐ Unknown 2 No 1 Yes 2 I signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No I ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital Other: 1 ☐ Yes 2 🗶 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending injury Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 24 hours after death Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

DHMH 17 Rev 06-2011

Registrar

State

29b. Signatu

31. Date filed (Month, Day,

title of certifie

4 2011

ne and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

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10062223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Lagible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month CT. Day 10 2011 Physician/ MARTIN GERARD DENVER 2:30P M Medical a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4107 E. Northern Parkway Baltimore Baltimore City 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Hours Nov. 6, 1946 Min 64 N.Y. **Director** 085-36-5303 1**X**XM 2 □ F Yrs. Usual Residence of Decede or 28a-f shov notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Baltimore City Maryland | Baltimore City 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ems 23a or must be r Funeral 21206 USA 4107 E. Northern Parkway 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, "natural", or iter Armed Forces? Black, White, etc. 1 X Never Married 2 Married þ 21215-0036 If Yes, Give 1966-1972 Year or Date 1966-1972 1 Yes 2x No Specify: Specify: White 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry (Specify only highest grade completed) atal Hygiene. ed other than "a event, the Mec life. DO NOT use retired) Elementary/Secondary (0-12) 12 yrs. College (1-4 or 5+) Northern Pharmacy Truck Driver Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) is marked o မ William Denver Josephine Dugan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a em 27 is 4725 Upper Beckleyville Rd. Hampstead, Md. 21074 Daniel E. Feustel (Brother-in-law) Department of Health Important: If item 27 any injury or other tronce. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State Garrison Forest V.A. 10-21-2011 4 ☐ Donation 5 ☐ Other (Specify) Owings Mill, Md. Signatur of Funeral Service Ligensee 22. Name and Address of Facility Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between mmediate Cause (Final nset and Death Physician/ **TCUTE** Myocardia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner tenos Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Physician/Medical Examiner The law requires that the death certificate be executed Cause (Disease or injury that initiated events sician and burial-trans Due to (or as a consequence of) resulting in death) Last attending physician Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Yes 2 No the 9 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Pres 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed 2 🗌 No Yes or Attending Physician: funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 21 No 1 Tyes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After tompletely filled in by the funer. 1 atural 5 Pending 1 Tes 2 🗌 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Hospital Medical Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and 29d. Date signed (Month, Day, Year) d cause of death (Item 23a) (Type, Print) 30. Name and HARRONO Rd SUTTE appenille MO MICHAR 31. Date filed (Month, Day, Year) State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For Amend Items 2 State Registrar	State of Ma	ryland Pe	/ Depa	rtment tificate	6/남3 of De	920 FTGH eath	Bental Hy	giene Reg. No.	2011	32734
			Registrar . Decedent's Name (First, Middle, Last)										3. Time of Death
	Physicia	_	Ida M. Durham							Month August	21,	2011	12 Noon ^M
Ŋ	Medic		a. Facility Name (if not institution, give str	eet and number)			4b. City, To	own, or Lo	ocation of Death		4c.	County of Dea	ath
	Examin	er	Lorien- Riverside				Be1c	amp	0411-	Lo pote et Di		arford	irthplace (State or Foreign
	Funeral	5	Social Security Number 6 Sex	M 2 TXT ⊑ I	(In yrs. last	birthday) Yrs.	If Under 1 Months		Hours Min.	8. Date of Bio (Month, Do	y, Year)	Ma	ountry) ryland
	Director		212-22-0918	8	34	115.				10-11-	1720		
	d iow		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation						10d. Inside City Limits 1 ☐ Yes 2 🔀 No
	arylan a-f sh fied a	sct		ford		Al	oingdo	n					
	or 28	흅	10e. Street and Number				10f. Zip (tizen of What (Country?
	with the 23a a	Funeral Director	3500 Thomas Pointe	Court A	Apt. 3	3C		210		76 - No No.		USA A	nerican Indian,
	tems termi	틢	11. Marital Status	Was Decedent E Armed Forces?		13.	Was Decede If Yes, specif	ent of Hisp ify Cuban,	oanic Origin? (Si Mexican, Puert	o Rican, etc.)		Black, Wh	nite, etc.
9	fter d , or i amin	þ	1 Never Married 2 X Married	1 ☐ Yes 2 X If Yes, Give	No		1 🗌 Yes 2	2 □X No	Specify:			Specify:	White
8	tural'	Completed	3 Widowed 4 Divorced 15. Decedent's Edu	Year or Dates.		16a. Dece	dent's Usual	l Occupat	ion	di-	16b. F	Kind of Busines	ss Industry
-51	72 hc n "na fledic	ğ	(Specify only highest grad	completed) College (1-4 or 5	54)	(Give life. L	kind of work OO NOT use	retired)	ning most of wo	Killy			
12	/ithin iene. r tha	ပိ	Elementary/Seconday (0-12)	College (1-4 of c	31)		Homema	aker			11.7.1.	Home	2
þ	iled w I Hyg othe	Be	17. Father's Name (First, Middle, Last)						18. Mother's Na	me (First, Middl .an D'Am			
lan	d be f Aenta arked tic e	유	Mario Massuralli						nd Number or R				Zin Code)
lary	should and h is ma		19a. Informant's Name/Relationship (Typ		Son	19b. Mai	ling Address Tarta	s (Street ar an Gr	een Ct.	Joppa	, Md	. 2108	5
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show Important: If item 27 is marked other than "natural", or items 2a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once.		Phillip N. Durham 20a. Method of Disposition	<u> </u>	20h Pl	ace of Dist	osition (Nan	ne of		Date	20c.	Location - City	or Town, State
ore	t of H If ite or off		1 ▼Burial 2 ☐ Cremation 3 ☐ I	Removal from State	CE	emetery, cr	moria	itner place	8-2	25-2011		Air, M	
ŧį	t. Pag tmen rtant:		4 ☐ Donation 5 ☐ Other (Specify, 21. Signature of Funeral Service License		ретн		22 Name an	nd Addres	s of Facility	Schimur	iek F	uneral	Home, Inc.
Bal	Depar Impol any ir			1/	1		610 T	W.Mad	cPhail E			, MD.	21014
	Physician		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only on Immediate Cause (Final disease or condition	Alz	2 he	mes	nter the mod	de of dying	g, such as cardia	c or respiratory	arrest,		Approximate Interval Between Onset and Death
	Medica Examine	_	resulting in death)	Due to (or as	a consequ	ience of):					1	4	<u> </u>
	_Adminio		Sequentially list conditions, if any, leading to immediate	b. Due to (or as	s a consequ	uence of):			- (1	M	LA	EXAMINER	
	ed	Examiner	cause. Enter Underlying Cause (Disease or iinjury						CERTIFICATION	N APPROVED B	(WEDICKI		
	be executed sician and burial-transi		that initiated events resulting in death) Last	Due to (or a	s a consequ	uence of):			1				
0	be executed sician and burial-transit	ical		d									
376	ficate ig phy as the	Med	IF FEMALE:									23d. Date of	of delivery
25 ×	h certi tendin vr use	Physician/Medi	23b. Was decedent pregnant	23c. If yes, outcom 1 ☐ Live Birth 4 ☐ Pregnant	n 2 L Fet	al death	B Ctopic	pregnant	су		_	Month	D \/
<i>₽</i> 8	deat the at	ysic	in the past 12 months? 1 ☐ Yes 2 No g ☐ Unknown	g Unknow									
180 90	es that the death certificate signed by the attending phy the detached for use as the	क्र	Part II. Other significant conditions co	ontributing to death	but not re	sulting in th	e underlying	g cause gi	ven in Part I.			2 🗆 No 3	ute to the cause of death?
いナゴ チェール Box 68760	ding Physician: The law requires that the death certificate h. h. Affer this certificate has been signed by the attending physfuneral director, page 2 should be detached for use as the	Completed		hypertenin, his facture, quit donnality 1 yes 2 24a. Was an autopsy performed? 1 yes 2 No								prid	re autopsy findings available or to completion of cause of ath? Yes 2 \(\sum \text{No} \)
	an: The	Be							Place of Death (C				
# 23	ysicia is cer direct	일	examiner?	Hospital:	atient 2		atient 3 🗆 I	DOA		g Home 5	Residence	e 6 Other njury occurred	(Specify)
	ig Phr ter thi		07 Manner of Dogth	28a. Date of i (Month, 12/07/	njury Day, Year)	28b. Tim inju	ry	28c. Inju wor				fe11	
Division	vitten deat ctor:	Certificate	2 XAccident Investigatio 3 Suicide 6 Could not be determined	28e. Place of	Injury - At h	nome, farm	, street, facto	-		28f. Locat		t and Number state) 1123	or Rural Route Number, Belcamp Garth
.2	To the Hospital or A within 24 hours after To the Funeral Direct completed filled in by	Modical Co		Nursi	of my kno	wledge, de	ath occured	at the tim	ne, date and place	ce, and due to the	ne cause(s) and manner	as stated. to the cause(s) and manner state ner as stated.
ji	he Ho in 24 he Fu iplete	Mod	(Check 2 Medical Examonly one) 3 Certifying Nu	se Practioner: To	the best of	my knowled	igo, acair ee		the time, date an se number	a place, and due			(Month, Day, Year)
	To the vithin com		29b. Signature and title of certifier	-w				22	2227		8	122	/ LI
	10		30. Name and address of person who	SYOJE	of death (Ite	em 23a) (Ty	pe, Print)	Phil	12 50	el Air /	no	2014	
		State	21 Date filed (Month Day, Year)		jistrar's Sig	nature &	u Nort	1 - (

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 0304 AM 2011 Medical 4c/County of Death 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death Saint Agnes Baltimore Hospital Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 88 **Funeral** Months Days Hours **Director** Usual Residence of Decedent 28a-f show 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland items 23a or 28a-f sho ner must be notified at 10d. Inside City Limits Completed by Funeral Director 1 Yes 2 □ No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21229 Was Decedent Ever in U.S. Arms a Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, of Health and Mental Hygiene. item 27 is marked other than "natural", or iten other traumatic event, the Medical Examiner Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 2 No f Yes, Give Year or Dates 1 🗌 Yes 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired)

NTACTOR (Specify only highest grade completed) College (1-4 or 5+) Be Father's Name (Fjrst, Middle, Last) 8. Mother's Name (First, Middle, Maiden Surname, မ ouise Informant's Name/Rei ionship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2 N. Monastery Ave. Bollo. Mb 21239 Department of Health ar Important: If item 27 is any injury or other trau 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Owings Mills, MD 21. Signature uneral Servic / Licer Fredhilton Riss Ballo mo 21229 the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death neart failure. List only one cause on each line. Immediate Cause (Final Ph_sician/ Acute on chaonic senal failure disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner elkalemie 1 day Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury or as a consequence of): Metabolic acidosis been signed by the attending physician and should be detached for use as the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical haonic obstauctive pulmonary Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has k page 2 autopsy performed 2 🗌 No Yes 1 Tyes Division of Vital filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Other: ဂ္ 1 Tes 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred Natural 5 \square Pending 1 🗌 Yes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 10/05/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maryland Baltimore Nadipelli S. caton Avenue 31. Date filed (Month, Day, Year) 32. Registrar's Si State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 32736 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ OCTOBER 9 Day 2011 Year LOUIS M. DOROBA, SR. 1:35 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 617 S. HARFORD SHAMROCK RD 8. Date of Birth (Month, Day, May 25, . Age (In yrs. last birthday) 9. Birthplace (State or Foreign If Under 24 Hrs. **Funeral** Days Months Min Country) MD 1 X M 2 🗆 F 84 Hours 1927 216-20-4819 Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director HARFORD BEL AIR 1 Yes XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? P 27 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be Funeral 617 S. SHAMROCK RD 21014 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 2 No þ XX Yes 2 If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: WHITE Specify: Completed XX Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) LOCKEED-MARTIN MACHINIST Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ည WEICHERT VICTORIA JOSEPH DOROBA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LOUIS DOROBA, JR. (SON) and 2 s Health a 1315 CHRISTOPHER CT BEL AIR, MD permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place, BEL AIR MEM GRDNS 10/14/2011 BEL AIR, MARYLAND 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME OF BEL AIR Signature of Funeral Service Licens 610 WEST MACPHAIL ROAD, BEL AIR, MD art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final 6/10 blestoma Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Examin that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ jo in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year g 🗌 Unknown g Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed a 23e. Did tobacco use contribute to the cause of death? Completed by Bie zure Disorder ATRIAL Pibrillation Records, No. 3 Probably 4 Unknown 1 Tyes Osteoarthriti 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy page To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No 25. Was case referred to medica **Division of Vital** 26. Place of Death (Check only one) examiner? Other: 1 Yes 2/No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 2 Accider work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. H41069 0 of death (Item 23a) (Type, Print) Center Way Edgewood Mayland 21040

Registrar DHMH 17 Rev 7/2009

State

State of Maryland / Department of Health and Mental Hygien ? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2:00 P M William J. Eveland 10/09/201 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baldwin 13111 Fork Rd Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 9. Birthplace (State or Foreign Country) MD 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 🖾 M 2 🗆 F 88 11/30/1922 Yrs **Director** 168-18-3799 Usual Residence of Decedent 28a-f show 10a. State 10b. County "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2x No Baltimore Baldwin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13111 Fork Rd. 21013 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ş Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: White Completed 3 Divorced 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Mechanical Engineer Communications should be filed with and Mental Hygien 7 is marked other the 12 permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Robert Austin Eveland Maude Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rose M. Eveland- Wife 13111 Fork Rd. Baldwin, MD 21013 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 K Burial 2 Cremation 3 Removal from State Gardens of Faith Cem. 10/13/2011 Rosedale, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home Inc. 21. Signature of Funeral Service Licenses Hel Belair Rd. Baltimore, MD 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final et and Death Physician/ Sonter disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury and cononomy sician and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): nding physician use as the burial Physician/Medical P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death signed by the a d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown plnous Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 2 1 No Yes Yes Division of Vital 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural $5 \square$ Pending work Accident Suicide 1 Yes 2 No after death Director: / d in by the f Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours after

To the Funeral Directory completed filled in by Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0027693 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6530 WALTher Ave Boltomore Maso Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 18^{Day} Marjorie Lillian Faulk 2011 2:10 p^M Sept. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Randallstown Northwest Hospital Center Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In vrs. last birthdav) **Funeral** Days Hours (Month, Day, Year) 220-24-7243 Director Mar. 3, 1927 Maryland 84 Usual Residence of Decedent r 28a-f shov notified at 10d. Inside City Limits 10c. City, Town or Location Director 1 ☐ Yes 2 🌠 No MD Baltimore Owings Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral USA 21117 4423 Marriottsville Road 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Dever Married 2 Married ö Completed by within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 M No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Hamburger's Dept. Store Seamstress 10th Grade nd Mental Hygier marked other t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Cornelia Snowden Henry Rhodes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health a 4423 Marriottsville Road Owings Mills, MD. 21117 James Johnson - Son other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date pernit. Page 1 a
Der artment of H
Important: If ite
any injury or ott . Page 1 1 M Burial 2 Cremation 3 Removal from State 9/27/2011 Owings Mills, Maryland Carrison Forest Vet. Cem. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Chatman—Harris Funeral Home 21. Signature of Funeral Service License 5240 Reisterstown Road Baltimore, MD. 21215 a. P. . . Enter the please, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ge PSIS Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner small Bowe chemia Due to (or as a consequence of) Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events and Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 use as IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy
5 Other (specify) Year Day Pregnant at time of death 1 Yes 2 9 Unknown q I IInknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 No ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending I 24 hours after death. 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 3 ☐ Suloido 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital within 24 hours a To the Funeral D Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c License number D29085

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 06-2011

State Registrar old COURT Road

RANDAILS + DWN, MD ZIL33

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5401

Allan J. Chircus

31. Date filed (Mwth Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State of Maryland / Department of Health and Mental Hygien Of State of Maryland / Department of Health and Mental Hygien Of State of Maryland / Department of Health and Mental Hygien Of Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ enelope 23.23 M Frankos 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Himone 6. Sex 7. Age (In vrs. last birthday) If Under 24 Hrs. 8 Date of Birth Birthplace (State or Foreign **Funeral** 1 M 2 XX Hours June 7, 1944 67 Maryland Director 215-42-8089 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits XX 1 Yes 2 No the Medical Examiner must be notified at Director N/A Baltimore Maryland 9 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral IISA 21211 3931 Keswick Road items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Black, White, etc. ò þ 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify. Specify: "natural", 3 Widowed 4 X Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Math Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be file h and Mental F is marked ot ဂ္ Katherine Kosmides permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. Nicholas Frankos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 619 St. Johns Road, Baltimore, MD 21210 Maria Durham Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/25/2011 Woodlawn, Maryland Greek Orthodox Cemetery 22. Name and Address of Facility Burgee Henss-Seitz Funeral Home, Inc 3631 Falls Road, Baltimore, Maryland 21. Signat re of Funeral Service Licensee 23a. Part 1. there the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ disease or condition Medical resulting in death) r as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) attending physician and for use as the burial-transit CERTIFICATION APPROVED BY MEDICAL EXAMINER The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Division of Vital Records, P.O. Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 month Month Year Day Pregnant at time of death ed by the a 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed t 23e. Did tobacco use contribute to the cause of death? þ Splatic Sportsome 2 No 3 Probably 4 Unknown Completed has been signed to the second 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page perform death? after death.

Director: After this certificate has in by the funeral director, page 1 🗌 Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours aff
to the Funeral Di
completed filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Micha 31. Date filed (Month, Day, Year, State

Registrar

State of Maryland / Department of Health and Mental Hygien 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Year tricla 7:10 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death BALTIMORE rauma n/a Social Security Number If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) Hours Min August 5, 213-46-3709 1 🗆 M 2 🕱 F Months 83 1928 Pennsylvania Yrs Director Usual Residence of Decedent 10b. County 10a. State the Maryland 10c. City, Town or Location 10d, Inside City Limits notified at Director Baltimore Maryland Towson 28a-f 1 Yes 2 X No ō 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be i Funeral 800 Southerly Rd., Unit 1808 21286 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner was Decedent Ever Armed Forces? 1 □ Yes 2 XX No Black, White, etc ö ģ 1 Never Married 2 X Married within 72 hours after Maryland 21215-0036 1 ☐ Yes 2XX No Specify. If Yes, Give Year or Dates "natural" Completed 3 Widowed 4 Divorced Specify: white the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) handiwork permit. Page 1 and 2 should be filed with Department of Health and Mental Hviringortant; if item 27 is manany injury or other quilting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Zug Margaret Wiest 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William C. Gardner/husband 800 Southerly Rd., Unit 1808 Towson, MD 21286 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Crematory Oct. 14,2011 Baltimore, Maryland 21. Signature of Funeral Service Licenses John O. Mitchell IV, Funeral Service of Dulaney Valley, 200 E. Padonia Rd. Timonium, MD 21093 Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Approximate** Immediate Cause (Final Onset and Death Physician/ 0 ranial ntra disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner GENTFICATION APPROVED BY MEDICAL EXAMINES Sequentially list conditions, Examine If any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence on burial-transit and Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Box 68760 the attending IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year 1 Urknown Pregnant at time of death the 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Vo 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? certificate 2 🗌 No Yes To the Hospital or Attending Physician: 25. Was case referred to medical filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 2 🗌 No 1 Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Director; After this 28a. Date of injury (Month, Day, 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at 1 Natural 2 Accident 5 Pending injury 1230 pm all hours after death. 12/1 Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 11210 010 CAT (1496 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Residence , mi) 21057 within 24 hours a

To the Funeral I

completed filled nen Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death 29b. Signature and title of 29d. Date signed (Month, Day, Year) 11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medi 31. Date filed (Month, Day, Year State 1 4 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink	Ensure All Copies Are Legible. 2011 32	7 L
State of Maryland / Department of H	ealth and Mental Hygiene	1

		1- For State Certificate of Death Reg. No.											
Physicia	_	1. Decedent's Name (First, Mid	ddle,Last)						2.	Date of Death			3. Time of Death
Medical Examii	ner	Ronald Thomas	Givens							Month Da October 4, 2	ay Yea 011	ſ	0729 hrs
		4a. Facility Name (if not institu	tion, give street and r	number)		4	b. City, Town, or	f Death		4c. County of Death			
		3514 Woodmoor Ro	ad				Gwynn Oak				Baltimor	e Cou	nty
Funeral		5. Social Security Number	6. Sex	7. Age (I	n yrs. last birl	hday)	If Under 1 Year	r If Unde	r 24Hrs.	8. Date of Birth(N	/M/DD/YYYY		
Director	ŀ	213-48-8448	1X M 2 F		55	Yrs.	Months Days	s Hours	Min.	11-6-195	5	Foreig Cou	n ^{untry)} MD
	- 1	Usual Residence of Decedent			- 55					11-0-175.		L	[1]
Aud	- 1	10a. State 10b. Coun	ty	10	c. City, Town	or Locatio	'n						10d. Inside City Limits
*	L	MD	Baltimore	ı	Gwynr	Ook							1 Yes 2 No
Maryland 28a-f show d at once.	용	10e. Street and Number	Darchible		GWYLL	1 Cak	10f. Zip Code		-	100	Citizen of What Country?		
e Man	ě						Tot. Zip Gode			l log.	Citizen of What Country?		
th the 23a c	Funeral Director	3514 Woodmoor Ro					2120	~			USA		
th wi	e l	11. Marital Status 1 Never Married 2	12. Was De	ecedent Ev Forces?	er in U.S.		Decedent of His s, specify Cuban				14. Race White		can Indian, Black,
or it	ᇍ		1 Yes	2 X	No							۸ حـ ـ :	A
s afte	ā		Divorced If Yes, Give Your Dates:				Yes 2 No						can-American
hours Exan	9	15. Decedent's Education (S				during mo	s Usual Occupat st of working life.	DO NOT	use retired		b. Kind of Bu		
16 n 72 n 72	Completed	Elementary/Secondary (0-1)	2) College	(1-4 or 5+)		Fork	lift Öpe stion	erato	r		Josep		Banks tion Union
withi withi withi	ξ		2			* 15 LL U						-	cion union—
Hyg Hyg		17. Father's Name (First, Midd	le, Last)				18.Mother's Name (First, M			irst, Middle, Maid	den Surname)		
121 J be f ental	Be	Henry Givens Doroth									ith		
MD 21215-0036 12 should be filed within 7 th and Mental Hygiene. 27 is marked other than umatic event, the Medica	١٩	19a. Informant's Name/Relatio	nship (Type, Print)		191	o. Mailing	Address (Stree	t and Num	ber or Rura	al Route Number	, City or Tow	n, State,	Zip Code)
nore, MD 21215-0036 sges I and 2 should be filed within 72 hours after death with the Maryland att of Health and Mental Hygiene. It: Vitem 27 is marked other than "natural", or item 23s or 28s-f shoother traumatic event, the Medical Examiner must be notified at once.		Dorothy Givens-Mo	ther		3	3514 W	oodnoor Ro	oad, G		ak, MD 212	207		
F Her		20a. Method of Disposition 1 X Burial 2 Cremati	on 3 Removal	from State		of Disposit ory or othe	ion (Name of cen er place)				c. Location -	City or	Town, State
Page ent o	ı	4 Donation 5 Other	_	nom otate	Mt. Zi	on Cer	netery		10-11	-11 I	ansdown	e, M)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 37 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	ı	21. Signature of Funeral Service				22. Na	me and Address	of Facility	T.X.1	ie Fineral	Home F	Δ	of Balto. Co.
E.E.G.B.	-	W Very W	SQ.			920) Liberty	Road		llstown. N			JI DAILW. W.
Physician	寸	23a. Part I. Enter the disease,	or complications that	caused the	death. Do no	ot enter the	mode of dying,	such as ca	rdiac or re	spiratory arrest,	shock, or hea	ırt	Approximate Interval
/Medical		failure. List only one caus		unchat V	Nounde								Between Onset and Death
£xaminer		Immediate Cause (Final diseas or condition resulting in death)			-								
	-	Coguentially list conditions	b.		,								
	힐	Sequentially list conditions, if any, leading to immediate	Due to (or as	a conseque	ence of):								
	盲	cause. Enter Underlying Caus (Disease or injury that initiated	C.										
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3760, fincate be g physici s the buri	Š,	IF FEMALE: 23b. Was decedent pregnant in			f pregnancy	_		-			23d. Date of		
68 certif nding se as	ä	past 12 months?	I I Live	birth nant at time	2 ofdeath ₅	=		Ectopic	pregnancy	′	Month Day Year		
Box 687. he death certificate of the attending of the death feet for use as till	Physiciar	1 Yes 2 No 9 U	nknown 9 Unkr		5	∪ Othe	er (Specify)						
C : the d	튑	Part II. Other significant cond			t not resulting	in the un	derlving cause g	iven in Par	t I.	23e. Did tobac	co use contri	oute to t	he cause of death?
P.O. es that the igned by be detach	<u>(</u> 조						, ,			1 Yes 2	No 3	Prob	ably 4 Unknown
w requires the been signal should be consignated by the constant of the consta	[译								_	24a. Was an			opsy findings available
OFG aw re as be 2 sho	쁿									autopsy	р	rior to co	ompletion of cause of
Pec The la	Completed									performed 1 ✓ Yes 2	No 1	eath? ✔ Ye	s 2 No
Vital Recysician: The his certificate director, page	Be	25. Was case referred to medic					26.Place	of Death (Check only	/ one)			
	0	examiner? 1 Yes 2 No	Hospital: 1	Inpatient	2 ER/O	utpatient	3 DOA	Other4	Nursing H	lome 5 Res	idence 6	Other:	Scene
ision of Attending Pher death.	-	27. Manner of Death	28a. Date	of Injury	28b. 7	Time of Inj	ury 28c. Injur	y at Work?		d. Describe how	injury occurre	ed	
endir ath.	₽		naing	h, Day,Year) D: 2011	FOU 0718		1 Y	es 2 🗸	No Su	bject shot			
r Att	<u>≅</u>		Colligation				factory, office bu	uilding, etc	. 28	f. Location (Stree	et and Numbe	r or Rur	al Route Number, City
Es af	Certification:	Outdoo		Single	Family H	ome			35	or Town, State 14 Woodmoor) Road, Gwy	nn Oak	, MD
		29a. Certifier	Physician: To the be				ed at the time. da	te and plac	ce. and du	e to the cause(s)	and manner	as state	d.
Divisi To the Hospital or Att within 24 hours after de To the Funeral Direct			aminer:On the basis	of examina									
To cor	ŠΙ	29b. Signature and title of certi	and manner	stated.	41		29c, License	number		29	d. Date signe	d (Mon	th, Day, Year)
		3/H5)/H	- Colle	mys			O.C.N	Λ.E.			ctober 5,		
	-	20. Namo and oddana of	- Vect	no of dead	/ltem 00=1								
		 Name and address of person Victor Weedn MD JE 				900 W	Baltimore St	reet Ra	altimore	MD 21223			
CA	10	31. Date filed (Month, Day, Year		egistrar's S						2 1220			
Sta Registr	~	0.00 1 4 2011	A. SZ. N	Signal S	San Ka	1							
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Physician/ Medical Examiner Examine ifficate be executed and -trar physician a the burial-

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IF FEMALE:

For State Registrar

10a. State

MD

Director

Funeral

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Completed

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Physician/

Medical

Examiner

Funeral

Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important, If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

2011

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OCTOBER

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BRENDA

Medical Physician/ 0

DIVISION OF VITAL DECOLUS, P.O. DOX O	To the Hospital or Attending Physician: The law requires that the death cer	within 24 hours after death.	To the Funeral Director: After this certificate has been signed by the attendi	completely filled in by the funeral director, page 2 should be detached for use		Modicial Contistant To De Octavial La Division
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2 No 3 Probably 4 Unknown 1 \square Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 No Yes 2 X No 1 Tes 26. Place of Death (Check only one) Hospital Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🕱 Other (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d, Describe how injury occurred 1 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge; occurred of the time, dete and place, and due to the course(s) and manner as stated 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 CRNP ORIGINAL

31. Date filed (Month, Day, Year)

JACKIE JONES,

25. Was case referred to medical

2 **X** No

5 Pending

examiner?

1 Yes

1 X Natural

Manner of Death

Accident

4 Homicide

29a. Certifier

(Check

29b. Signature and t

Suicide

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.	1 /	2271.1.
State of Maryland / Department of Health and Mental Hygiene	1	32144

		1- For State Registrar		Certi	ficate of	Death			Reg	g. No.		
Physici Medical Exami	an/	Decedent's Name (First, Middle, LOUIS ALLEN GOO							Date of Death Month October 8,		r	3. Time of Death 2115 hrs
>		4a. Facility Name (if not institution, Upper Chesapeake Me	41	o. City, Town BelAir								
Funeral Director		219-86-5105		(In yrs. Iast	t birthday) Yrs.	If Under 1 Months	Year If Unde Days Hours		3 / 5 / 1	964	Foreig	hplace (State or n untry) MD
any	ŀ	Usual Residence of Decedent 10a. State 10b. County	11	Oc. City, To	own or Locatio	n	<u>.</u>					10d. Inside City Limits
E .,	_	MD HARFOR			NGDON							1 Yes 2 No
eath with the Maryland items 23a or 28a-f show ust be notified at once.	Director	10e. Street and Number 2824 BYNUM OVER				10f. Zip Coo				g. Citizen of Wh	at Coun	itry?
vith the		11. Marital Status	12. Was Decedent E	ver in U.S.	13. Was		f Hispanic Orig	in? (Speci			- Ameri	can Indian, Black,
5 72 hours after death with the Maryland 11 "natural", or items 23a or 28a-f she 12 Examiner must be notified at once	/ Funeral	1 Never Married 2 Married 3 Widowed 4 Divor	ied Armed Forces? 1 X Yes 2 Deed If Yes, Give Year	No	If Ye		uban, Mexican,			White Specify:	e, etc. WHI	ГE
ours af atural	d by	15. Decedent's Education (Specif	l or Dates: y only highest grade comp	leted) 1			upation (Give I			16b. Kind of Bus	siness/I	ndustry
5-0036 led within 72 ho dygiene. other than "na	Completed	Elementary/Secondary (0-12)	College (1-4 or 5-		during mo		ife. DO NOT HANIC	use retired)	FLOOR I	NST	ALLING CO.
MD 21215-0036 d 2 should be filed within 7. th and Mental Hygiene. a 27 is marked other than numatic event, the Medical		17. Father's Name (First, Middle, L	ast)				110			aiden Surname)		
121 Id be fill Mental B	o Be	ROBERT GOODMAN 19a. Informant's Name/Relationship	(Type Print)	- 1	19h Mailing	Address (9		SSA MA		per, City or Town	n State	Zin Code)
MD 2 d 2 shou lith and h	۲	LISA GOODMAN-WI			-		OVERLOO			IGDON, M		
Te, I I and Health	-	20a. Method of Disposition 1 Burial 2 X Cremation			ace of Disposit	ion (Name o			ate	20c. Location -		
Pages Pages nent of ant: If		4 Donation 5 Other Spe		9	ANTIC (ORY	10/1	7/11	GLEN BU	JRNI	E, MD
Baltimore, MD 2's permit. Pages I and 2 should Department of Health and MImportant: If item 27 is mainjury or other traumatice.		21. Signature of Funeral Service Li	censee									E OF BELAIR
Physician	\dashv	23a. Part I. Enter the disease, or co		ne death. D						R, MD 21 st, shock, or hea		Approximate Interval
Medical Examiner	8	failure. List only one cause or Immediate Cause (Final disease	each line. a. Multiple Injuries									Between Onset and Death
LAMIIIICI		or condition resulting in death)	Due to (or as a consec	uence of):								
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consec	uence of):								
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760, icate be physic the bur		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome	of pregnar			. —			23d. Date of		
Box 687 death certific the attending perforuse as the	Physician	past 12 months?	1 Live birth 4 Pregnant at ti	me of death	=	il death er (S <i>pecify)</i>		pregnancy	/	Month	D	lay Year
Bo he deat the at hed for	hys	1 Yes 2 No 9 Unkno	9 OINTOWN		Iraa ta maasa	de de de en en			Too. Did to	and the sector	huto to	the cause of death?
ires that the signed by	ā	Part II. Other significant conditio	15 contributing to death	out not resu	liting in the un	deriying cau	ise given in Pa	irt I.				ably 4 Unknown
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Certification:	27. Manner of Death 1 Natural 5 Pendin 2 ✓ Accident Investi		21 21 2	8b. Time of Inj 2027 hrs	ury 28c. 1[Injury at Work¹ Yes 2 ✓	No Or		ow injury occurre motorcycle ir		sion with motor
Divisal or At a safter da la Direct de in by	rtific	3 Suicide 6 Could	not be 28e. Place of Inju	-		, factory, off	ice building, etc		or Town Sta	ate)		ral Route Number, City d, Belcamp, MD
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Phy	sician: To the best of my	knowledge,	death occurre			ice, and du	e to the cause	(s) and manner	as state	ed.
To the within To the compl	Medical	one) 2 Medical Examination 29b. Signature and title of certifier	ner: On the basis of exam and manner stated.	nation and	or investigation		cense number	curred at th	e time, date a	29d. Date signe		
. \ .		Con Con A O	N/nnnn.				.C.M.E.		}	October 9,		,, ,
131,84	-	30. Name and address of person w	ho completed cause of de									
10		— — ·	stant Medical Exam	iner 90	00 W. Baltii	more Stre	eet, Baltimo	ore, MD	21223			
Si Regis	ate trar	31. Date filed (Monthly, Yea)	32 Registrar's	Signature	jav. Balti							

OCME

Physician /Medical Examiner

Funeral

Director

death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.
Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Examirer must be routlied at once.

Baltimore, Maryland 21215-0036

nding physician and use as the burial-trans atter for u ed by the a detached f

spital or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760, Records, Division of Vital

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erti	25. Was case referred to medical examiner?	26. Place of Death (Check only one)								
this certific al director, To Be (1 Yes 2 10	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 [DOA Other: 4 Nursing H	Home 5 ☐ Residence 6 ☐ Other (Specify)						
death. ctor: After the y the funeral	27. Manner of Death 15. Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurred						
after Dire I in b	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, fabuilding, etc. (Specify)	ctory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
24 hour Funer etely fill dical	29a. Certifier Check only one) Certifying Ph	ysician: To the best of my knowledge, death occi niner: On the basis of examination and/or investig and manner stated.	irred at the time, date and place ation, in my opinion, death occu	e, and due to the cause(s) and manner as stated. urred at the time, date and place, and due to the cause(s)						
vithin Fo the compl	29b. Signature and title of certifier		29c. License number	29d. Date signed (Month, Day, Year)						
> = 0	In Sugi	, ND	D57531	October 13. 2011						
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) No but by 8661 Vetera is nevy necessitie m D 2110									
State Registrar	31. Date filed (Month, Day, Year) OCT 1 4 201	22. Registrar's Signature	, .	,						

		1 - For State Registrar		Cel	rtificate of D)eath		gienę. Reg. No.	2011	327	40
Phy	sician/	Decedent's Name (First, Mide	dle, Last)				2. Date of De			3. Time of	Death
Ň	/ledical	James Lee Ho 4a. Facility Name (if not institution)			1h Oil Trum or	Leastion of Do	Octobe	r 10		6:18	A M
EX	aminer		a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital Olney Montgomery								
	eral	5. Social Security Number	6. Sex 7. Age	e (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hi Hours Mi	n. (Month, Da	th y, Year)	9. Birth Cou	nplace (State or ntry)	_
Dire	-	206-26-0045 Usual Residence of Decedent	1 X M 2 □ F	77 Yrs.			Jan 19	, 19:	34 Penr	nsylvan:	ia
ryland	ied at	10a. State 10b. Coun	ıty	10c. City, Town or Lo	cation					10d. Inside Cit 1 ☐ Yes	
he Ma or 28a	notifi Dire	MD Monto	gomery	Silver Spr	ing 10f. Zip Code	-		10a. Citi	izen of What Cou		ZAL NO
s 23a	er must be notified at Funeral Director	2901 S. Leisur	re World Blvd.	#101	20906			USA			
ITE, MIGITYIGITY ZIZIO-UUSO 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show	xaminer n	1 ☐ Never Married 2X M	If Yes, Give	No .	Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 😿 No	n, Mexican, Pue	Specify Yes or No- erto Rican, etc.)		14. Race - Amer Black, White Specify:	, etc.	
0-00 hours	dical E	15. Deced	ed Year or Dates. 1 dent's Education thest grade completed)	16a. Deced	dent's Usual Occupa	ation	vorking	16b. Ki	Whi		
thin 72 ane. than "	the Medical Exa	Elementary/Secondary (0-12		i+) life. D	kind of work done d O NOT use retired)	uring most of w	rorking		3 0		
iled wit Hygie other	ent, th	17. Father's Name (First, Middle	, Last)	Audit	or	18. Mother's N	lame (First, Middle,		ral Gove Surname)	ernment	
Vialryland Should be filed v h and Mental Hyg 7 is marked othe	atic ev	James Lungar H	Ioward			Jean Wo	Womelsdorf				
2 shouth and the and 27 is m	traum	19a. Informant's Name/Relation Trene Helen Ho	1 1 2 1 2 1		ng Address (Street a S. Leisur						
1 and of Heal	other	20a. Method of Disposition	-	20b. Place of Dispo	osition (Name of		Date		ocation - City or		
Dallillor Department of Mportant: If it	lury or	1 ☐ Burial 2X☐ Cremation 4 ☐ Donation 5 ☐ Other	on 3 Removal from State (Specify)	Final Jou	rney Crem	atory 1	0/13/11	Wood	dbine, N	1D	
partitioner, permit. Page 1 and 3 Department of Healt Important: If item 2	any in	21. Signature of Funeral Servi	e Licengeey	G	2. Name and Addres	Cremati	on Servi	ce l	P.O. Box	784	
•		23a. Part 1. Enter the disease, shock, or heart failure. Lis	or complications that caused	MO1251 Be the death. Do not ente	er the mode of dying	, such as cardi	ac or respiratory as	rrest,		Approximate	3
Physic		Immediate Cause (Final disease or condition	Athe	rosc kro	tic Car	rdiov	ascular	Ais	sease	Interval Bety Onset and D	
Med Exam		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. A the solution of the consequence o									
	je je	Sequentially list conditions,	Tryper	1 2 7 37 05						14. 37. 33. 44	- 25
		if any, leading to immediate	Duo o (or as a	a consequence of):						year	<u>C</u>
ecuted	-transit xamil	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	S o	a consequence of):						year	<u> </u>
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tificate be executed ng physician and	as the burial-transit Medical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	S o	a consequence of):						yea.	<u> </u>
ath certificate be executed attending physician and	for use as the burial-transit	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	c	a consequence of): a consequence of): of pregnancy 2 Fetal death 3	Ectopic pregnanc	у			23d. Date of deli Month		'ear
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DHMH 17 Rev 06-2011

State Registrar

DHMH 17 Rev 7/2009

29b. Signature and title of certifier

Date filed (Month, Day, Year)

4

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MEnto

00 t

200 MEMORIAL AUG

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 32748 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Year Month Day Physician/ A M 1013 ANTHONY Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death N/ABALTIMORE FDICAL ENTER Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Funeral Days Hours Min 1 M M 2 🗆 F 213-08-0647 42 Maryland **Director** Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location death with the Maryland Examiner must be notified at Director N/A Baltimore 1 Yes 2 No MD 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 21223 USA 520 N. Carrollton Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian Black, White, etc. ō 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 M No Specify: Specify: Black "natural", 3 Divorced 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Labor Ready Waste Management <u>12th Grade</u> other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ၉ Josephine Trehern Robert Hill permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 520 N. Carrollton Avenue Baltimore, MD. 21223 Josephine Hill - Mother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 M Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Windsor Mill, Maryland 10/15/2011 King Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Chatman-Harris Funeral Home 4210 Belair Road Baltimore, Maryland 21206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ACQUIRED NEAR disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examiner Dunito (or as a nonsequence of cause. Enter Underlying or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events -tran and Due to (or as a consequence of): resulting in death) Last the burial physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as 1 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No for Pregnant at time of death Unknown Month Dav Year signed by the at d be detached fo g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s has performe Yes 2 No certificate 1 ☐ Yes 2 No 25. Was case referred to medical director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death filled in by the funeral 28c. Injury at 28a. Date of injury (Month, Day, Year) 28b. Time of After t Certificate: 28d. Describe how injury occurred 1. Natural 5 \square Pending work?
1 Yes 2 No within 24 hours after death To the Funeral Director, A 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed 3 🗆 29b. Signature and title of certifig 29c. License number 29d, Date signed (Month, Day, Year) MIL MD 2011 D64307

State Registrar DAVID

A

31. Date filed (Month, Day, Year)

54.

PAVL

PLACE

301

Registrar's Signature

BALTIMORE

21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

VITBERG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State of Manyland Opportune of Health and Mental Hygiene Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Scorembe 26 2011 Physician/ HALL-LUNN ANETTE 6:12 AM Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baitmore St. Joseph Social Security Number Medical Center TOWSON If Under 1 Year If Under 24 Hrs.

Hours Min. 8. Date of Birth
(Month, Day, Year)
08-06-1 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1 □ M 2 💢F 216-56-6782 Yrs MD **Director** Usual Residence of Decedent Department of Health and Mental Hygiene. Important, or items 23a or 28a-f show Important; if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. once. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland Director PARKVILLE 1 ☐ Yes 2 🌠 No MO 10g. Citizen of What Country? 10e Street and Number Funeral 21234 USA Forres 1 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Armed Forces? Black, White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: BLACK Completed 3 Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry VERIZON WIRELESS College (1-4 or 5+) Elementary/Seconday (0-12) TOMER SERVICE Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည ANNIE MCCANN AUSTRALIA HALL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) PARKVICLE, MD. 21234 HUSBANO LUNN 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 10/7/11 BALTIMOYE, MD Arbutus Cemetery 4 ☐ Donation 5 ☐ Other (Specify) permit. I 22. Name and Address of Facility VHU6HN GREENE FUNERAL SCVS 21. Signature of Funeral Swice Lensee 4905 YORK ROAD. BALTIMORE, MO. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory awest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Due to (or as a con Juence of) **Examiner** Asystole Sequentially list conditions, if any, leading to immediate cause. Enter Underlying CERTIFICATION APPRIATED BY MEDICAL EXAMINER Examiner Due to (or as a consequence of) within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit 0515 Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Hospital or Attending Physician: The law requires that the death Month Vear Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Medical Certificate: To Be Completed by ー件公分の子具-Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 N 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 17 N 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 🔀 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: In the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Fractioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier ept. and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 405rou

31. Date filed (Month, Day, Year)

DRIVE

Osler

M.D

2. Registrar's Signature

labassi

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene A for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 6:40 PM OCTOBER 2011 Frank Joseph Hornack Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death Examiner 4b. City, Town, or Location of Death BALTIMORE SAINT JOSEPH MEDICAL CENTER TOWSON If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) . Age (In yrs. last birthday, Funeral Days 216-20-1494 Director 1**X**] M 2 □ F 87 3/18/1924 Maryland ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10a State 10h County 10c. City, Town or Location Director 1 Yes 2 No MD Harford Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3400 Tulleys Pointe Crt 21009 U.S.A 12. Was Decedent Ever in U.S. Armed Forces?
1 ⚠ Yes 2 ☐ No
If Yes, Give 10/3 - 1 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. er than "natural", or i 1 Never Married 2 Married Completed by 3altimore, Maryland 21215-0036 Specify: White 1 Yes 2 No If Yes, Give Year or Dates, 1943-1945 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Engineer Sparrows Point and Mental Hygier is marked other t Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Hornack Annie Miklorvich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 622 Ponderosa Drive, Belair, MD 21014 Nephew Steve Scherba 20b. Place of Disposition (Name of Parkwood matery or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Parkville,Md. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Funeral 9705 Bc 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Retween Onset and Death Immediate Cause (Final Physician/ ENCEPHALOPATHY disease or condition resulting in death) ANOXIC Medical Due to (or as a consequence of): **Examiner** ARDIAC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): ARRHYTH MIA that initiated events Due to (or as a consequence of resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Year Pregnant at time of death 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CORONARY ARTERY DISEASE 1 Yes 2 No 3 Probably 4 Unknown Completed PERIPHERAL VASCULAR DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 🗌 Yes 2 Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ours after death.

neral Director: Aff 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Jurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 🗌 D24034 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OSLER DRIVE, TOWSON, MARYLAND TIMOTHY LOW m.D. 7601 31. Date filed (Month

DHMH 17 Rev 06-2011

Registrar

Box 68760

Records,

Division of Vital

			For State Registrar	State of Maryla		tificate of D			Reg. No.								
	5.	,	Decedent's Name (First, Middle, L	ast)				2. Date of Dea	ath	3. Time of Death							
	Physicia Medio		Nancy E. Hall					October	4,2011	7:19P M							
para ma	Examir		4a. Facility Name (if not institution, gi	· ·		4b. City, Town, or			4c. County of	Death alto.							
			17 Tearose Dri 5. Social Security Number 6.		t11-14	Mi If Under 1 Year	ddle Riv										
	Funeral Director		220-40-8857	Sex 1 M 2 XF 7. Age (In yrs. 67	last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Da 1-31-	y, Year) [944 We	. Birthplace (State or Foreign Country) est Virginia							
	how at	<u>_</u>	Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits							
	arylar a-f sl	ecto	Md Balt	1	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Middle R	iver			1 ☐ Yes 2 X No							
	or 28 or 28 e not	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	at Country?							
	with s 23a ust b	era	17 Tearose Driv	<i>r</i> e		212	20		USA								
	death item: item:	표	11. Marital Status	12. Was Decedent Ever in L Armed Forces?	J.S. 13. V	Vas Decedent of His Yes, specify Cuban	spanic Origin? (Sp	ecify Yes or No-		American Indian, White, etc.							
980	rs after (ral", or Examir	ed by	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates.		☐ Yes 2 🗓 No			Specify:	White							
15-0	s filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decedent's (Specify only highest	grade completed)	(Give I	lent's Usual Occupa kind of work done do O NOT use retired)	tion uring most of wor	king	16b. Kind of Busir	ness Industry							
212	led within Hygiene. other tha ent, the N		Elementary/Seconday (0-12) 12th	College (1-4 or 5+)	Book	Keeper			Furnitu	re Store							
ore, Maryland	filed al Hy d oth event	o Be	17. Father's Name (First, Middle, Las	t)			18. Mother's Nan	ne (First, Middle,	Maiden Surname)								
	lld be Ment arker atic	2	Charles Dayton				Edna	Broadwat	er								
	1 and 2 should be file f Health and Mental F item 27 is marked o other traumatic eve		19a. Informant's Name/Relationship Robert M. Hall	(Type, Print) Spouse		g Address (Street ar Tearose 1			r, City or Town, State River, Md								
	Page 1 and ment of Heal ant: If item 3 ury or other		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State	Place of Dispo cemetery, cren	natory or other place	10-	Date 8-2011	20c. Location - Ci	•							
	2243		4 Donation M Other (Spe			. Name and Address											
Ba	permit Depar Impor any in		By- all	le	1				Funeral								
	Physician/ Medical Examiner		23a. Part 1. Enter the disease, or co shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Duy to or as a conse	quente of):	ailure ndone	, such as cardiac	or respiratory an	rest,	Approximate Interval Between Onset and Death							
3760	ficate be executed g physician and as the burial-transit	Medical Examiner	Esquer tially flet ear diffione, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	Due to (or as a consect of the conse	quence of):	noone	riac	Cano		1 7 7405							
Box 68	death certif ne attending ed for use a	ysician/Mec	ıysician/Med	nysician/Me	nysician/Me	Physician/Me	nysician/Me	ysician/Med	ysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🕱 No 9 ☐ Unknown	23c. If yes, outcome of pregr 1 Live Birth 2 Fe 4 Pregnant at time or 9 Unknown	tal death 3	Ectopic pregnancy Other (specify)	y		23d. Date of Month	
P.O.	hat thed by detact		Part II. Other significant conditions	contributing to death but not re	esulting in the u	nderlying cause give	en in Part I.	23e. Did to	obacco use contribu	ite to the cause of death?							
<u>8</u>	uires t n sign lid be	ed by						1 🗆	Yes 2 No 3	☐ Probably 4 ☐ Unknown							
Division of Vital Records,		Completed						24a. Was autor perfo	psv pric	re autopsy findings available or to completion of cause of th? Yes 2							
E F	Physician: The lav this certificate has ral director, page 2	Be C	25. Was case referred to medical	1		26. Pla	ice of Death (Che		2 Noj IL	res 2 - Ro							
Ĭ;	lysici is cer direc	To B	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	☐ ER/Outpatier	t 3 DOA Othe	r: 4 Nursing F	lome 5 Resid	dence 6 🗆 Other (Specify)							
n of	nding Ph th. : After th : funeral		27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident Investigat	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work? M 1 🗆 `	at		now injury occurred								
ivisio	I or Attendation after deation Director.	Certificate	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	be 290 Place of Injury At I		eet, factory, office		28f. Location (S City or Tox		or Rural Route Number,							
Ω	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral	Medical	(Check 2 Medical Exa	nysician: To the best of my kno miner: On the basis of examinati	on and/or invest	igation, in my opinior	n, death occurred	at the time, date a	and place, and due to	the cause(s) and manner state							
	o the vithin (ž	only one) 3 Certifying No. 29b. Signature and title of certifier	urse Practioner: To the best of I	my knowledge, o	leath occurred at the 29c. License		ace, and due to th	e cause(s) and mann 29d. Date signed (A								
	r. M		, ,	a. m' Auce	20												
	08		30. Name and address of person who		m 23a) (Type, F	rint)											
			William	P. Mª Gulir	0 911	7 France	lin So	(1ano	br. Bal	to MUL 23							

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death 2011 Year October 12, 2:40A **MARGARET JONES** 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Stella Maris Timonium Baltimore 8. Date of Birth (Month, Day, Year) . Social Security Number 7. Age (In yrs. last birthday) If Under If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country) 219-22-9351 1 □ M 2**XX**F 82 Yrs 11/30/1928 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 🗆 Yes 2 🗓 Xio Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 Ecoway Court #20 21286 USA

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036 Physician/ For State Registrar

MARY

Physician/

Medical

Director

Examiner

Funeral

Director

2:40 а.ш.

OCTOBER 12, 2011

Medical **Examiner**

physician and s the burial-transit

Division of Vital Records, P.O. Box 68760

y Fu	11. Marital Status 1 ☐ Never Married 2 🛣 Married	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes XX No	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)					14. Race - American Indian, Black, White, etc.			
q pe	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates.	1 🗆 🕆	res 2 XIX Io	Specify:			Specify: W	nite		
Completed by	15. Decedent's Ed (Specify only highest gra		16a. Decedent's Usual Occupation (Give kind of work done during most of working				16b. Kind of Business/Industry				
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Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam			Surname)			
မ	John J. McEntee										
	19a. Informant's Name/Relationship (Ty	Town, State, Zij	o Code)								
	James Edward Jone	36									
	20a. Method of Disposition 1 XX Burial 2 Cremation 3	Removal from State C6	lace of Disposition emetery, cremator	y or other plac	re)	Date		ocation - City or			
	☐ Donation 5 ☐ Other (Specification)	Dular			dens 10/15				Maryland		
	2 / ignature of Funeral Service Arens	New arkes	22. Nar	ne and Addre	^{ss of Fac} MMitch Road Bal	ell-Wie	defe Mar	eld Fune	eral Home Inc 21212		
-	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final	e cause on each line.						-222	Approximate Interval Between Onset and Death		
	disease or condition resulting in death)	a. ALZHEIMERS Due to (or as a consequence)	ence of):								
Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequence of):									
<u>m</u>	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury										
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Mec	IF FEMALE:						_				
Completed by Physician/Medical Examiner	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 X No 9 ☐ Unknown	23c. If yes, outcome of pregnar 1 Live Birth 2 Fetal 4 Pregnant at time of d 9 Unknown	death 3 Ectopic pregnancy					23d. Date of delivery Month Day Yea			
۲.	Part II. Other significant conditions co	ontributing to death but not resu	ulting in the under	ying cause giv	ven in Part I.	23e. Did to	obacco u	use contribute to	the cause of death?		
ed b)						1 🗆	Yes 2	□ No 3 □ P	Probably 4 🗆 Unknown		
omplet						24a. Was autor perfo	rmed?	prior to death?	utopsy findings available completion of cause of		
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	27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	28b. Time of injury N	work	28c. Injury at work? 28d. Describe h			iow injury occurred			
edical Certificate:	3 Suicide 6 Could not be 4 Homicide determined								ral Route Number,		
Medica	(Check 2 Medical Exami	sician: To the best of my knowle ner: On the basis of examination be Practitioner: To the best of m	and/or investigation	on, in my opinio	on, death occurred a	t the time, date a	nd place	, and due to the	cause(s) and manner stated.		
	29b. Signature and title of contifier	chalf		29c. License				te signed (Mont			

State

Registrar

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

30. Name and addless of person who completed cause of death (Item 23a) (Type, Print)

JACKIE JONES,

4 2011

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 11 per inf g923 1-26-12 vt
State of Maryland / Department of Health and Mental Hygiene 20 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death CONBER Physician/ LONES UANITA 10:50 P M 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death urton svill ross Tgomer Age (In yrs. last birthday) 8. Date of Birth Under 1 Year If Under 9. Birthplace (State or Foreign **Funeral** Hours 1 M 2 W 81 Director Carolin June Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits and 2 should be filed within 72 hours after death with the Maryland **Funeral Director** notified 28a-f 1 Yes 2 No 10e. Street and Num ms 23a or must be n ò 10f. Zip Code 10g. Citizen of What Country 2078 items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Yes 2 No If Yes, Give Year or Dates. ō 1 X Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Black "natural" Completed 3 Widowed 4 Divorced of Health and Mental Hygiene. item 27 is marked other than "natul other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Service lerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Sland homas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or To. n. State, Zip Code) Department of Health an Important: If item 27 is any injury or other traconce. homasene 4a son 52 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Location - City or Town, State Page 1 g 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) autenceville -17-2011 22. Name and Address 21. Signature of Funeral Service Licensee an 701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CEPSIS Ph. sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) burial-transit Cause (Disease or imjury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician I for use as the buria Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death the detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ FIVAL STACT ISEASG END Division of Vital Records, 1 Tes 2 No 3 Probably 4 Unknown Completed page 2 should 24a. Was an 24b. Were autopsy findings available has autopsy prior to completion of cause of death? within 24 hours after death.

To the Funeral Director; After this certificate I completed filled in by the funeral director, page 1 🗌 Yes 2 🗷 No Yes 25. Was case referred to medical æ 26. Place of Deat | Check only one) examiner? Other: 2. No မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manuar of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred Natural 5 Pending injury work? 2 Accident
3 Suicide 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 2 Medical Examiner. On the basis of examination around investigation, in my opinion, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 285 13 ms) Weller 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2835 BACIO MD Sm 1774 ASNEEM Dav. Year Date filed (Month) Registrar's Signa State OCT 1 4 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician JOSEPHI JAJIELSKI 9:20 PM SEPTEMBER 2011 16 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Johns Hopkins Bavview Medical Center **Baltimore** 8. Date of Birth (Month, Day, Year) August 24, 1931 Birthplace (State or Foreign Country)
 Maryland If Under 1 Year | if Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F 80 Director 213-26-6381 Usual Residence of Decedent 10a State 10d. Inside City Limits 10h. County 10c. City. Town or Location 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Dundalk Maryland Baltimore 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 23a or 21222 **USA** 7850 Rock Bourne Road Funeral "natural", or Items 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 □ No !f Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No White Specify. þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Is marked other than 12 years Operating Engineer Bethlehem Steel Pages 1 and 2 should be filed nent of Health and Mental Hygir 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gertrude Kwaka Joseph M. Jagielski Sr. ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health ar
Important: If Item 27 Is
any Injury or other trau 7850 Rock Bourne Road, Dundalk, Maryland 21222 wife Helen Jagielski 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State September 1 Durial 2 Cremation 3 Removal from State Sacred Heart of Jesus Cem 21, 2011 Dundalk, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Lome Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** IDIOPATHIC DISEASE Lung WEEKS disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner 2.5 YEARS KHEMMATOID ARTHRITIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence of CERTIFICATION APPROVED BY MEDIC Due to (or as a consequence of) 本名の十五 for for mig C Division of Vital Records, P.O. Box 68760, s certificate has been signed by the attending physician a director, page 2 should be detached for use as the buna Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 [9 ☐ Unknown 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown HOUTE KIDNEY MJURY Completed NSTEMI 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performe 2 No ACUTE RESPIRATORY 2 🗌 No DISTRESS SYNDROME 1 Tes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) 2 110 ၉ within 24 hours after death.

To the Funeral Director; After this completely filled in by the funeral of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 1 🗹 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and marner as stated Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number RES-000 SEPTEMBER 16 2011

State Registrar

DHMH 17 Rev 1/2001 11595 4940 Eastern Avenue, Baltimore, MD, 21224

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

M.D.

32. Registrar's Signature

PATHAK

SUJAY

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney Certificate of Death Reg. No. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Physician/ Manth 8:16 P M Medical 4a. Facility Name (if not institution, **Examiner** give street and number) 4b, City, Town, or Location of Death County of Death Himore [ast birthday) 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) 7. Age (In yrs **Funeral** Months Days Hours **Director** Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** notified 28a-f 1 Yes 2 No 10 10e. Street and Numbe 10g. Citizen of What Country? 10f. Zip Code þe 23a must items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ ò 1 Never Married 2 Married filed within 72 hours after Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: "natural" 3 Divorced 4 Divorced Completed Year or Dates event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) of Health and Mental Hygiene. item 27 is marked other that other traumatic event, the N Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MACKS Department of Healt Important: If item 2 any injury or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donatifon 5 Other (Specify) Signature Funeral Service Lie Name and Address of Facility 23a. P 1 1 fitter he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shown heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedia Cause (Final Physician/ disease or condition resulting in death) Medical Du to (or as a consequence of) **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? signed by the atte Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 🗌 Yes 2 No 3 Probably 4 Unknown 2 should peen 24b. Were autopsy findings available 24a. Was an has autopsy performed prior to completion of cause of death? After this certificate I 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital 2 No Other: မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending 1 Tes 2 No Accident Investigation Funeral Director: sted filled in by the Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Direc determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar AS

aduos

MD

DHMH 17 Rev 7/2009

22

Certificate of Death

2. Date of Death

OCTOBER

Day 2,

2011

3. Time of Death

6:20AM

1 - For State Registrar

MARIA

Physician/

Medical

1. Decedent's Name (First, Middle, Last)

R.

KAIL

Examir	5941 DAYBREAK TERRACE						4b. City, Town, RASPI	or Location of Deat EBURG	h	4c. County of Death BALTIMORE		
Funeral Director		5. Social Security Nu 216 36 0	073	Sex 1 ☐ M 2 🔏F	7. Age (In yrs. I. 72	ast birthday Yrs.) If Under 1 Year Months Days			**/****939	9. Birthplace (State or Foreign	
Maryland :8a-f show rtified at	rector	Usual Residence of I 10a. State MD	Decedent 10b. County BALTIM	IORE	1	y, Town or	Location EBURG				10d. Inside City Limits 1 □ Yes 2 🍇 No	
with the As 23a or 2 ust be no	Funeral Director	10e. Street and Num 5941 DAY		TERRAC	E		10f. Zip Code	21206		10g. Citizen of V	What Country?	
1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status 1 ☐ Never Marrie 3 ☐ Widowed 4		Armed For	2 X No	3. 13	B. Was Decedent of I If Yes, specify Cub	oan, Mexican, Puert	pecify Yes or No- o Rican, etc.)	Blac	ce - American Indian, ck, White, etc. :: WHITE	
within 72 hou giene. ner than "nati er, the Medica	3 Widowed 4 Novorced If Yes, Give Year or Dates. 15. Decedent's Education (Specify only highest grade completed) Elementary Seconday (0-12) College (1-4 or 5+) OFFICE MANAGEMENT CH								16b. Kind of B	SPEC		
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Page 1 ar ment of He ant: If iter ury or oth		20a. Method of Dispo 1 X Burial 2 4 Donation	Cremation 3	☐ Removal from	State C	emetery, cr	position (Name of ematory or other pla OOD CEM	10/	Date 17/11	l	- City or Town, State	
permit. Page Department or Important: If any injury or once.		21. Signature of Fund	eral Service Lice	nsee			22. Name and Addr 1 2 1 1 CHE				FUNERAL HOME, MD 21237	
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical Examiner	23b. Was decedent p in the past 12 m 1 Yes 2 9 Unknown	onths?		Birth 2 ☐ Feta nant at time of d	I death 3	Cther (specify)	су			ate of delivery onth Day Year	
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DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	State of Maryland / Department of Health and Mental Hygiene 20 1 3 2 7 5 7																
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		To the Hospital or Attending Physician: The law requires within 24 hours after death. To the Funeral Director: After this certificate has been sig completely filled in by the funeral director, page 2 should b	Medical	29a. Certifier 1 (Check 2 only one) 3	■ Medical Exa	hysician: To the best aminer: On the basis lurse Practitioner: 1	of examina	tion and/or inve	stigation, in	my opinio	n. death o	ccurred at	the time, date a	nd place	and due	to the cau	se(s) and manner stated.
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 32758 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year ILLIAW Month 2348 Oct 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 10WARO 020 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday) If Under **Funeral** 1 X M 2 □ F **Director** Usual Residence of Decedent of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No 10e, Street and Number 10g. Citizen of What Country? Funeral USA Was Decedent Eyer in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Maryland 21215-0036 1 Yes 2 No Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) COMPUT Elementary/Seconday (0-12) Be 17. Father's Name (First, Middle, Last) (First, Middle, Malden Surname) t. Page 1 and 2 should be fill thent of Health and Mental tant: If item 27 is marked or ٩ 1 ASHINGTON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2/645 HOURS Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of ± 5 Burial 2 Cremation 3 Removal from State Department o Important: If any injury or Donation 5 Other (Specify) real Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Ph_sician/ ANOXIC BRAIN disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner CARDIO PULMONAIZ ARREST Sequentially list conditions, Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence or To the Hospital or Attending Physician: The law requires that the death certificate be executed THEROGEREROTIC CARDIOVASCULAR DISEACE been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Live Birth 2 Pregnant at time of death Unknown in the past 12 months? Month Day 1 Yes 2 9 Unknown 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by PARKINGONS DIJEASE 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? FRTENSION 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s autopsy perform 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 Inpatient 2 - ER/Outpatient 3 - DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred 1 A Natural 5 Pending injury 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DO04366

00 11/2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 1. Decedent's Name (First Middle Last) 2. Date of Death Physician/ Month October Grace 4:30A Kruelle 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death SEASONS HOSPICE BALTMORE RANDALLSTOWN Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days (Month, Day, Year) 1 🗆 M 2 💆 F **Director** 214-01-5254 99 NOV 16,1911 MARYLAND show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director MD 28a-f BALTIMORE LOCHEARN 1 Yes 2 X No 0 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 6825CAMPFIELD ROAD Funeral 23a ROOM 109 21207 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
 U Yes 2 No Specify: 11. Marital Status 14. Race - American Indian Examiner Black, White, et WHITE þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 filed within 72 hours after "natural", Completed 3 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) l Hygiene. I **other than "** Elementary/Secondary (0-12) College (1-4 or 5+) 12 SECRETARY MANUFACTURING CO Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ JOHN P ZEPP FRONA MAE SHAFFER and lis m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 street of Health a tant; If item 27 is DONNA K ADAMS 8165 PLEASANT PLAINS RD TOWSON, MD. 21286 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date mit. Page 1 a partment of H portant; If ite y injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) PARKWOOD OCT 15,2011 PARKVILLE ,MD per mi Der ar Imp or any in 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC durulo 6415 BELAIR ROAD BALTIMORE, MD. 21206 23a. Part 7. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shirts, or heart failure. List only one cause on each line. Approximate Interval Between End. Stage Dementia Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) certificate be executed the burial-transi Due to (or as a consequence of): physician Physician/Medical Box 68760 use as attending IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day signed by the at 4 ☐ Pregnant at time of death 9 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Hospital 6 Other (Specify) Other: in 24 hours area and the Funeral Director: After this completely filled in by the funeral directors. မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending work? 1 Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Frantition or Tell woods only the only of cause of the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier

1 Skyrpanu M D 29c. License number 29d. Date signed (Month, Day, Year) 10/13/11 DOUS7465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD 21209 203 31. Date filed (Momin, Day, Year

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 6:25 PM 2011 Henry Kelly Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner N/ABaltimore Good Samaritan Nursing Center If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 🔀 M 2 🗆 F Months Hours 03/12/1923 Virginia Director 223-26-8422 88 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 √ Yes 2 □ No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1716 East 28th Street 21218 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ed other than "natural", or i þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industr (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore City permit. Page 1 and 2 should be filled within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainmain. Elementary/Seconday (0-12) College (1-4 or 5+) Housing Authority 12th Grade Housing Management Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Kelly Mary Bullock Henry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1716 E. 28th St., Baltimore, MD 21218 Latanya Dawson (GrDaughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 \square Burial 2 \boxtimes Cremation 3 \square Removal from State cemetery, crematory or other place) On-Site Cremation 10/21/11 Baltimore, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses Joseph H. Brown Jr. Funeral Home, 2140 N. Fulton Ave, Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ Sta End disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter ornorrying Cause (Disease or linjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23d, Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Day Vear Yes 2 No been signed by the sahould be detached g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ VASEle 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has lirector, page 2 s autopsy performed?

1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA this 27. Manner eath 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 atural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 ho To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 5601 Loch Ravan Blud B. Hinne 30. Name and add ses of person who completed cause of death (Item 23a) (Type, Print) errance 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

			Pleas	e Type or Pr					-	_	ible.
			For State Registrar	State of IV	aryland /		tment of F ficate of D		nd Mental Hy	Reg. No.	11 32761
	Physicia	an/	1. Decedent's Name (First, Middle, L	,	o a a a				2. Date of D Month		3. Time of Death
e en	Medi Exami	cal	Anna E. 4a. Facility Name (if not institution, gi		ogan		1b. City, Town, or	Location of		4c. County	1/ 7:07 PM
	\			V	Spita	/	Rose	dale		Ba	Himore
	Funeral Director			Sex 1 ☐ M 2 🌠 F	je (Infyrs. last b 78		If Under 1 Year Months Days	Hours		irth lay, Year) 1933	9. Birthplace (State or Foreign Country) Marvland
	nd at	,	Usual Residence of Decedent 10a, State 10b, County		10c. City, To	own or Locat	tion				10d. Inside City Limits
	Marylar 28a-f sl atified	recto	MD Balti	more			Esse	ζ			1 ☐ Yes 2 No
	death with the Maryland items 23a or 28a-f sho ner must be notified at	Funeral Director	10e. Street and Number 421 Dorsey Ave.				10f. Zip Code	21221		10g. Citizen of V	What Country?
9	eath wi	Fune	11. Marital Status	12. Was Decedent	Ever in U.S.	13. Wa	s Decedent of Hi	spanic Origin	n? (Specify Yes or No	l	e - American Indian,
9800	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	1 Never Married 2 Married 3 🛣 Widowed 4 🗆 Divorced	Armed Forces? 1 ☐ Yes 2X If Yes, Give Year or Dates.	No		es, specity Cuba		Puerto Rican, etc.)	Specify:	k, White, etc. White
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Maryland 21215-0036	should be filed within 72 n and Mental Hygiene. 7 is marked other than " raumatic event, the Mec	To Be	17. Father's Name (First, Middle, Last Charles	,	Altvate	er			s Name (First, Middle vian	e, Maiden Surname E •	White
Mar	12 shou lith and 27 is m r traum		19a. Informant's Name/Relationship Staci Ann Logan		I .	-			or Rural Route Numb 1timore, 1		
ore,	e 1 and of Hea If item or othe		20a. Method of Disposition 1 Burial 2 Cremation 3		20b. Place ceme	e of Disposit	ion (Name of ory or other plac	e)	Date	20c. Location -	City or Town, State
Baltimore,	permit. Fage 1 and 2 sh Department of Health an Important: If item 27 is ny injury or other trau		4XX Donation 5 ☐ Other (Spe- 21. Signature of Fungral Service Uige	cify)	Unifo				0/13/2011		esda, MD
Ba	Dep (mb)	11.3	I Table Ditale	meun	100382	, Ra 93	3 Gist	ral can Ave.,	d Cremation Silver Sp	on Servio ring, MD	20910
			23a. Part 1. Eriter the disease, or co shock, or heart failure. List only Immediate Cause (Final	mplications that cause one cause on each lin	d the death, Do	o not enter t	he mode of dying	g, such as ca	rdiac or respiratory a	rrest,	Approximate Interval Between Onset and Death
	Ph sician/ Medical		disease or condition resulting in death)	a. Fata Due to (or as	a consequenc	e of):	thmi	<u>a</u>			Oriset and Beatin
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	uted d ansit	Examiner	If any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	o UTI	a consequenc	e oī):					
	be executed sician and burial-transit	cal Ex	resulting in death) Last	Due to (or as	a consequenc	e of):					
68760		Medic		d							
Box 68	Hospital or Attending Physician: The law requires that the death certificate by a hours after death. Funeral Director: After this certificate has been signed by the attending physisted filled in by the funeral director, page 2 should be detached for use as the both of the funeral director.		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a	2 Fetal de	ath 3 E	ctopic pregnanc other (specify)	У		23d. Dat Mor	te of delivery nth Day Year
P.O.	requires that the debeen signed by the should be detached	y Phy	Part II. Other significant conditions	contributing to death k	out not resultin	g in the und	erlying cause giv	en in Part I.	23e. Did	tobacco use contr	ibute to the cause of death?
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Division of Vital Records,	The law re ate has be page 2 sho	Completed	-						_ per	opsy formed?	Nere autopsy findings available prior to completion of cause of death? □ Yes 2 □ No
tal	Physician; The r this certificate heral director, page	Be	25. Was case referred to medical examiner?	Hospital:					(Check only one)	2 No 1	T I TES 2 I NO
of Vi	ding Phys h. After this of funeral dir	e: 10	1 Manner of Death	1 ☐ Inpati	ent 2 ⊠ ER/e ry 28b	. Time of	28c. Injury	4 ∟ Nurs at	ing Home 5 Res	idence 6 Othe	
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_	To the Hospital or a within 24 hours after To the Funeral Dire completed filled in bire that the fille	Medical	(Check 2 ☐ Medical Exar	ysician: To the best of niner: On the basis of e irse Practioner: To the	xamination and	d/or investiga	ation, in my opinio	n, death occu	irred at the time, date	and place, and due	e to the cause(s) and manner stated
	To th withir To th сопр		29b. Signature and title of certifier			ougo, uca	29c. License		ia piace, and due to t	29d. Date signed	l (Month, Day, Year)
	•	$ \ $	10					226C	4	Octobe	er 7,2011
			30. Name and address of person who	completed cause of d	eath (Item 23a		t)	0	~ 3 '		C12 -=

State Registrar

-ogan Anna

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 25 per me, g920, 10/13/2011dhb rar Certificate of Death Reg. No. 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day Physician/ Month Virginia Carol McCulley 1115 10 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FRANKLIN SQUARE HOSPITAL Rosedal Baltimore If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8 Date of Birth Funeral 7. Age (In vrs. last birthday) Decenth, 23 Year 925 1 M 2 K F Days Hours Min. 220-20-3778 85 New York Director Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Parkville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3414 Putty Hill Avenue 21234 USA Virgini death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. "natural", or þ 1 Never Married 2 Married 2 XNo 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: white Completed 3 Wildowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Black and Decker Accounts Receivable Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MCCAL Thurston Henry Himelright Elizabeth Anna Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3414 Putty Hill Avenue-Parkville, Maryland 21234 Carol Schiller-daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Parkwood Cemetery 1 X Burial 2 Cremation 3 Removal from State Oct.8,2011 Parkville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel and Cremation Services 8800 Harford Road- Parkville, Maryland 21234 L-MEJ endrae 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Pneumoperitoneum
Due to (or as a conseque ce of): Physician disease or condition Medical resulting in death) Examiner Perforation Bowel Sequentially list conditions, Physician/Medical Examiner it any seeding to him sold cause. Enter Underlying Cause (Disease or iinjury that initiated events EXAMINER attending physician and I for use as the burial-tran CERTIFICATION APPROVED Due to (or as a consequence of): resulting in death) Last Physician: The law requires that the death certificate be ± 4 ± 6 ± 6 Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Dav Pregnant at time of death Arter this certificate has been signed by the ifuneral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an for the propulation of the propulation of the funeral Director. After this certificate has I for the Funeral Director. After this page 2 s performed? Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: ၉ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 10-5-2011 D72364 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRANKLin Square DR Balto md 21237 Devadatta Sarwate 9000 32. Registrar's Sinature State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last)
James F. Mar Markowski Month 10/14/2011 Physician/ 2:30am Medical 4a. Facility Name (if not institution, give street and number)
1420 Decatur Street 4b. City, Town, or Location of Death Baltimore 4c. County of Death N/A Examiner 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Date of Birth 9. Birthplace (State or Foreign Social Security Number 219–32–7443 **Funeral** 1 🔀 M 2 🗆 F Months Days Hours Month, Pay, Year 7/7/1935 76 **Director** MD Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MD N/A Baltimore City Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1420 Decatur Street 21230 USA 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever III Stock Armed Forces?

1 Noves 2 No Air
If Yes, Give Force
Year or Dates. Korean War Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2XXNo Specify. Specify: 3 Widowed 4 XXDivorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nould be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) 12 College (1-4 or 5+) Shipping Longshoreman any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o James S. Markowski Brokus Frances 19a. Informant's Name/Relationship (Type, Print)

Morag Payne / Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1420 Decatur Street, Baltimore MD 21230 20b. Place of Disposition (Name of cemetery, crematory or other place)

Ardent Crematory 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2XXCremation 3 Removal from State 10/15/2011 Hanover MD 4 Donation 5 Other (Specify) 21. Signature of Euneral Service License Victor P. Doda 22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Avenue, Baltimore MD 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Colon Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or iinjury that initiated events resulting in death) Last andtran Due to (or as a consequence of): burial attending physician for use as the buria Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Year Pregnant at time of death Unknown ed by the a 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Deparders Records, 1 Ses 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician: The law 1 24 hours after death. Funeral Director: After this certificate has E autopsy performed death? 1 Yes 2 7 Yes 2 Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2010 Hospital: Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Amesidence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, þ determined Medical 29a. Certifier 1 Zertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certific 10575 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2/230

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

68760

Box

m)

East

DEMAL

hysici Exam				Reg. No. 2. Date of Death Month Day Year September 25, 2011	3. Time of Death 2145 hrs
		. 4a. Facility Name (if not institution, give street and number) 121 Rabbit Chase Drive	b. City, Town, or Location of Death Laurel		
uneral rector		5. Social Security Number 256-13-4472 6. Sex 17. Age (In yrs. last birthday) 52 Yrs.	If Under 1 Year If Under 24Hrs. Months Days Hours Min.	5/8/59 For	Birthplace (State or eign Country) GA
28a-f show any l at once.	.o.	Usual Residence of Decedent 10a. State GA Seminole 10c. City, Town or Location Dor	nalsonville		10d. Inside City Limits 1 X Yes 2 No
23a or 28a-f sho notified at once.	Director	10e. Street and Number 310 Alexander Avenue	10f. Zip Code 39845	10g. Citizen of What Co USA	ountry?
, or items 2	Funeral	1 Never Married 2 Married Armed Forces? If Ye	Decedent of Hispanic Origin? (Sps, specify Cuban, Mexican, Puerto Yes 2 No specify:	Rican, etc.) White, etc.	erican Indian, Black, Black
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Education (Specify only highest grade completed) 16a. Decedent's during mo	s Usual Dccupation (Give kind of w st of working life. DO NOT use retir	vork done 16b. Kind of Busines	s/Industry
ntal Hygiene rked other th ent, the Med	Be Com	17. Father's Name (First, Middle, Last) Harbert Moore		(First, Middle, Maiden Surname)	
th and Me 1 27 is ma umatic ev	٩			Rural Route Number, City or Town, Sta e, Lithonia GA 30	
ment of Heal tant: If iten or other tra		1 Burial 2 Cremation 3 Removal from State crematory or othe St. John	Cemetery 1	Date 20c. Location - City of 0/01/2011 Donalso	onville, GA
In por		Signature of Funeral Service Licensee Victor Doda Char 150	me and Address of Facility Les L. Stevens 11 E. Fort Avenu	Funeral Home, Inc e, Baltimore MD 2	1230
sician edical miner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, Complications of adenocarcinoma or Due to (or as a consequence of): Sequentially list conditions,		respiratory arrest, shock, or heart	Approximate Interval Between Onset and Death
id ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): c. Due to (or as a consequence of): d.			8 0
ysician ar burial - tr	edical	UNPENDED AMENDED			
signed by the attending physician and be detached for use as the burial - transit		Pregnant at time of death	I death 3 Ectopic pregnar	23d. Date of delive	ery Day Year
signed by the detache	۵	Part II. Other significant conditions contributing to death but not resulting in the unc	derlying cause given in Part I.	23e. Did tobacco use contribute t 1 Yes 2 No 3 Pr	
After this certificate has been uneral director, page 2 should	Completed				
nis certil director	o Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	26.Place of Death (Check o	nly one) g Home 5 Residence 6 ✔ Oth	er: Scene
	\vdash	27. Manner of Death 1 Natural 5 Pending 2 Accident Next Investigation 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury (Month, Day, Year)	ury 28c. Injury at Work?	28d. Describe how injury occurred	
neral Dire	Certification	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, (Specify)		28f. Location (Street and Number or F or Town, State)	
To the Fo	edica	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	n, in my opinion, death occurred at	the time, date and place, and due to	the cause(s)
	2	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (M September 26,	
	_	30. Name and address of person who completed cause of death (Item 23a)			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ september 29 Year 1 5:28Pm Lillian M. MaCoy Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Atlantic General Hospital Berlin Worcester Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗶 99 Months Days Hours Min. 0870871912 391-07-7074 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Worcester Berlin 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11647 Beavchamp Road, Apt 85 21811 USA death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 72 hours after White 1 Yes 2 No Specify: If Yes Give 3 Widowed 4 Divorced Year or Dates Page 1 and 2 should be filed within 72 hour ment of Health and Mental Hygiene. tant; If item 27 is marked other than "natuiny or other traumatic event, the Medical inry or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Hairdresser Salon Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Louis P. Minnie Ryaning Hansen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patti Serp - daughter 11647 Beauchamp Rd., Apt 85, Berlin, MD 21811 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other th Baltimore, aCoy 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date unk 1 Durial 2 Cremation 3 Removal from State cemetery, crematory or other place) Allentown, PA Greenwood Crematory 4 S Donation 5 ☐ Other (Specify) 21. Signature of diferal Service Lic Name and Address of Facility IIAM 1232 Midvalley Dr., Jessup, PA nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ Advanced Dementia disease or condition Medical resulting in death) Examiner Chronic Kidney Disease Sequentially list conditions, list cause. Enter Underlying Cause (Disease or linjury that initiated events as well than the conditions of Physician/Medical Examiner Due to for as a nonsequence of Colon Cancer the Hospital or Attending Physician; The law requires that the death certificate be executed the attending physician and the for use as the burial-transi Due to (or as a consequence of) resulting in death) Last Pulmonary Nodules Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No ate has been signed by the atte page 2 should be detached for Year ☐ Pregnant at time of death☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Tunknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate Yes 2 XNo 1 Yes 2 No To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🕱 No မှ 1 Inpatient 2 XER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural work? 1 Yes 2 No injury 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Xcertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) R 131285 September 30, 2011 30. Name and address of person who completed ca se of death (Item 23a) (Type, Print) 2 Bernal-Clark FNP-BC. 9715 Healthway Dr., Berlin, MD

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 32766 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3, Time of Death Physician/ Ellen Metzler ቸ0711/2011 5:45p Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Howard Columbia Gilchrist Hospice Care Social Security Number Age (In yrs. last birthday)
76 Yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 🗆 M 2 🗶 F Days 214-30-5087 Hours Country) **Director** Usual Residence of Decedent 10c. City, Town or Location
Baltimore 10a. State 10b. County at 10d. Inside City Limits Completed by Funeral Director notified MD Baltimore 28a-f 1 Yes 2 X No r items 23a or iner must be r ö 10e. Street and Number 10f. Zip Code 21227 10g. Citizen of What Country? 3013 Freeway USA should be filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian er than "natural", or ite the Medical Examiner Armed Forces?

1 Yes 2 No Black, White, etc 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White Yes, Give 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Industrial 6 Factory Worker event, Be 17. Father's Name (First, Middle, Last) . Mother's Name (First, Middle, Maiden Surname) dna Sheldon of Health and Mental H fitem 27 is marked ot r other traumatic ever မ Clifton Lee Green Edna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3013 Freeway, Baltimore, MD 21227 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Howard G. Metzler / Husband Baltimore, 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 10/17/2011 MD veteran Cemetery Crownsville, MD 4 Donation 5 Other (Specify) rice Drense Bailey Funeral Home and Cremation Service, PA M01452 4023 Annapolis Rd., Halethorpe, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ VULVAR CANCER Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Exam Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) Pregnant at time of death 1 Yes 2 No 9 Unknown the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown icate has been siç r, page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 No 2 No 1 Yes To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, t 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 🗶 No 1 Yes ျှ HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 X Natural 2 Accident (Month, Day, Year) 5 Pending 1 Tes 2 No М Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certi License number **264395** 29d. Date signed (Month, Day, Year) OCTOBER 12, 2011

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

DANIEUE DOBERMAN, MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6336 CEDAR LANE COLUMBIA, MD 21044

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - State Amend Item 25	State of Maryland / Dep per me,g920.10/0/	artment of H 7/2011dhb ertificate of l	lealth and M Death				32761
Physici	an.	Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day	Year	3. Time of Death
/Medic		Kacie Michele Mille				August 3	1		7:00 A M
Examir	er	4a. Facility Name (If not institution, give stre	eet and number)		Location of Death		4c. County		_ 1
		8523 Creek Road 5. Social Security Number 6. Sex	7. Age (In yrs. last birthday		dena If Under 24 Hrs.	8 Date of Birth	Anne A		.E.L ace (State or Foreign
Funeral Director			1 225 F 14 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 7/6/97	Year)	Coun	land
		Usual Residence of Decedent	1.4			1/0/21			
yland		10a. State 10b. County	10c. City, Town or L	ocation				10	Od. Inside City Limits
Mar Mar	to	MD Anne Arun	del F	asadena					1 Yes 2 No
h the	Director	10e. Street and Number		10f. Zip Code		10	g. Citizen of V	Vhat Coun	try?
15 will	al	8523 Creek Road		211	22			USA	
be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or Items 23s or 28e-f show event, It is Medical Examinar must be notified at	Funeral	11. Marital Status	. Was Decedent Ever in U.S. 13. Armed Forces?	Was Decedent of H	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		e - Americ k, White,	
or It		1 Never Married 2 Married	1 ☐ Yes 2. No If Yes, Give	1☐ Yes 2 No	Specify:		Specify	T.71.	at the second
ural.	d by	3 Widowed 4 Divorced	Year or Dates:	adoptio I lovel Oppus	ntion		6b. Kind of Bu		ite
n 72	Completed	15. Decedent's Educa (Specify only highest grade of	completed) (Giv	edent's Usual Occup e kind of work done o DO NOT use retired	during most of work		GD. Raid of Do		,
withi ene. than	m c	Elementary/Secondary (0-12)	College (1-4or 5+)	Student		ł	Scho	o1	
filed Hygi other		17. Father's Name (First, Middle, Last)		J G G G G G G G G G G G G G G G G G G G	18. Mother's Nam	e (First, Middle, M	taiden Sumam	18)	
ld be ental ked c	To Be	Timothy Ziler			Michele	e Lee Mil	ler.		
2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, ILEMS	-	19a. Informant's Name/Relationship (Type	, Print) 19b. Mai	ling Address (Street	and Number or Rur	al Route Number,	City or Town,	State, Zip	Code)
7.2 mg		Michele Lee Miller	/ Mother 8523	Creek Ro	ad Pas	adena, M			
s 1 ar		20a. Method of Disposition	20b. Place of Disp cemetery, cre	position (Name of ematory or other place		Date	20c. Location -	City or To	wn, State
permit. Peges Department of I Importent: If It any in ury or o		1 2 Burial 2 ☐ Cremation 3 ☐ Rer 1 4 ☐ Donation 5 ☐ Other (Specify)	Loudon P	ark Cemet					Maryland
permit. Per Departmen Importent: Inny in ury		21. Signature of Funeral Service Ligensee		22. Name and Addre					
Per Imp	9 3/3	23a. Part1. Enter the disease, or complica shock, or heart failure. Listionly one		620 Wilke				yrand	21229
Physician Medical Physician of Samular (Medical Physician and Medical Physician and Getached for use as the prival-transit	dical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	kto non	AVresi nia chemi	c en	1/	27	3 (3)212
tificat ig ph) as th	led				CERTIFICATION	NAPPROVED BY N	EDIONE		
The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Med	IF FEMALE: 23b Was decedent pregnant in the past 12 months? 1 □ Yes 2♥ No 9 □ Unknown		☐Ectopic pregnancy				te of delive onth	ery Day Year
that ned b		Part II. Other significant conditions contr	buting to death but not resulting in the	underlying çause gıv	en in Part I.	23e. Did tob	acco use cont	ribute to t	he cause of death?
w requires that s been signed I should be det	pa	JEIZHVE DUSUI	der Spalic =	gradury	185.6	1 □ Ye	s 2 🗆 No	3 Prot	oably 4 Unknow
aw re	Completed by					24a. Was a autops		Were auto	psy findings availab
The I	E	Pation Was	in DIR stat	J-5		perform	ned?	death? 1 □ Yes	•
ian: rtifica	Be C	25. Was case referred to medical examiner?			26. Place of Dea	th (Check only on	e)		
hysic I dire	70	1 Yes 2 No	spital: 1 Inpatient 2 ER/Outpati		4 Nursing H		nce 6 Oth	- '	5)
ding P h. After tl funera		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Time Injury	Wor	rk?	28d. Describe ho	w injury occur	red	
or Atten ifter deat Director: in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)		Yes 2 □No	28f. Location (St City or Town		per or Rura	al Route Number,
To the Hospitel or within 24 hours afte To the Funeral Dir completely filled in	Medical C	29a. Certifier Certifying Physic (Check only one)	cian: To the best of my knowledge, dea r: On the basis of examination and/or and manner stated.	ath occurred at the til investigation, in my o	me, date and place opinion, death occu	, and due to the carred at the time, d	ause(s) and ma ate and place,	anner as s and due t	stated. o the cause(s)
To th To th	Ř	29b. Signature and title of certifier	YUVAL SHAFRIR,	1)41	19304	Marytan	d. Date signe	31-	2011
4		YUVALSHAFRII		est Belv.	edere A	verme, 5	inte 32	891	timoro MD.
Sta	_	31. Date filed (Month, Day, Year)	32. Registrar's Signature	backer		,			

	1 - For State Registrar	- State of Maryle		rtment of Health tificate of Death		Reg. No.	327		
cian dical	1. Decedent's Name (First, Mide	Gloria I. M	iller		2. Date of De Month	Day Year Oct 8, 2011	3. Time of De 1:55		
iner	4a. Facility Name (If not institution 1176	on, give street and number) 64 Clarksville Pike		4b. City, Town, or Location	of Death	4c. County of De	ath Howard		
al or	5. Social Security Number 218-28-2529	4 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	rs. last birthday) 80 Yrs.	If Under 1 Year If Under Months Days Hours	Min. (Month, Da	9. B ay, Yea <i>r</i>) 1 5, 1931	irthplace (State or I Country)		
,	Usual Residence of Decedent 10a. State 10b. Count		City, Town or Loc				10d. Inside City		
cto	MD	Howard		Clari	ksville		1 □ Yes 2		
ral Director	10e. Street and Number 11764 Clarksville	Pike		10f. Zip Code 10g. Citizen of What Country U.S.A					
by Funeral	11. Marital Status 1 □ Never Married 2 □ Ma 3 □ Widowed 4 □ Divorce	If Vac Give	If	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 ☑ No Specify: 1 □ Yes 2 ☑ No Specify: Specify: White					
Completed	15. Decede	ent's Education est grade completed) College (1-4or 5+)	(Give k	ent's Usual Occupation kind of work done during mos O NOT use retired) Registered N	•	16b. Kind of Busines	Business/Industry Health Care		
To Be Co	17. Father's Name (First, Middle	Joseph Perna		18. Moth	er's Name <i>(First, Middle</i>	l o, Maiden Surname) squelina Palus	80		
	19a. Informant's Name/Relation Ann Miller Daug	hter	1176	Address (Street and Numb 4 Clarksville Pike		21029			
	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (3 Li Removal from State		ition (Name of atory or other place) Memorial Gardens	Oct 12, 2011	20c. Location - City of Marrio	or Town, State		
S S S S S S S S S S S S S S S S S S S	21. Signature of Funeral Service	e Licensee Burth	QZG ² 22.	22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043					
	23a. Part 1. Emer the dise ster shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	or complications that prosed the de st only one cause on each line. a. Due to (or as a cons	CAN	or the mode of dying, such as	s cardiac or respiratory a	arrest,	Approximate Interval Betwee Onset and De		
Examiner	Sequentially list conditions, if any, leading to immediate cause. Either Underlying Cause (Disease or injury that initiated events resulting in death) Last	b							
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 → No 9 □ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3 🗌	Ectopic pregnancy Other (specify)		23d. Date of o	delivery Day Ye		

Physicia /Medic Examin Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

Medical Certification: To Be Completed

To the Funeral Director; After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and

24a. Was an autopsy performed? 1 □ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 1 Natural 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

8343 Chemplane, Laurel, No 20107

24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No

of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year)

(Check only one)

1 4 2011

State

11-07586 Jason Owenson Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2011 32769
State of Maryland / Department of Health and Mental Hygiene

		- For State Registrar	Cert	ificate of	Death			Re	eg. No.	
Physician Medical Examine		1. Decedent's Name (First, Middle,Last) Jason Todd Owenson		-				Date of Dea Month October 1	Day Year	3. Time of Death 0612 hrs
)		4a. Facility Name (if not institution, give street and nur 2401 Autumn View Way	nber)	4	b. City, Town, c Parkville	r Location	of Death		4c. County of Baltimore	
Funeral Director		481-96-4877 1XM 2 F	7. Age (In yrs. las 36	st birthday) Yrs.	If Under 1 Ye Months Da				th(MM/DD/YYYY) 23 , 1974	Birthplace (State or Foreign Country) Towa
Maryland 28a-f show any d at once.	5	Usual Residence of Decedent 10a. State 10b. County Maryland Baltimore		own or Location						10d. Inside City Limits
death with the Maryland or items 23s or 28s-f sho must be notified at once	Director	10e. Street and Number 2401 Autumn View Way			10f. Zip Code 2123	4			og. Citizen of What United S	•
IMORE, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-fabs or other traumatic event, the Medical Examiner must be notified at once To the Townships of the Fernand Discontinuents	by runeral	11. Marital Status 1 Never Married 2 Married Armed Fo 1 Yes 3 Widowed 4 Divorced or Dates: 15. Decedent's Education (Specify only highest grad	2 X No	If Ye	Decedent of H s, specify Cuba Yes 2 No	n, Mexicar	n, Puerto Rio	can, etc.)	14. Race - White, Specify:	White
ID 21215-0036 should be filed within 72 hours after and Mental Hygiene, 77 is marked other than "natural", or natic event, the Medical Examiner 1 To Be Completed by E	Completed by	Elementary/Secondary (0-12) College (1-12) 4		during mo	st of working life	e. DO NOT	use retired)	Pharmac	
21215-0036 Juld be filed within 7 Mental Hygiene, marked other than ic event, the Medica		7. Father's Name (First, Middle, Last) David Clifton Owenson		·-·				irst, Middle, M Ann Hi	Maiden Surname)	· · · · · · ·
and 2 should the lealth and Men trem 27 is marticever traumatic every T.O. I.O.		9a. Informant's Name/Relationship (Type, Print) Laura Owenson (Spouse)				et and Nur	nber or Rura	al Route Num	ber, City or Town,	
Baltimore, MI permit. Pages I and 2 s Department of Health at Important: If item 27 injury or other traum.		0a. Method of Disposition 1 X Bunal 2 Cremation 3 Removal fro	- OL-1- CEE	ace of Dispositematory or other	ion (Name of ce	w Weby I	D	ie, Mar er 15, 1		City or Town, State
Baltimore, permit. Pages 1 a Department of He Important: If ite injury or other tr	k	4 Donation 5 Other Specify: Parkwille, Mar 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services—Par 8800 Harford Road Parkville, Maryland 21234								
Physician /Medical Examiner		23a. Part I. First the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on cause on each line. Immediate Cause (Final disease a.Alcohol and Meperidine Intoxication								
		or condition resulting in death) Due to (or as a obsequentially list conditions,	onsequence of):							
ed nsit Examiner		cause. Enter Underlying Cause Disease or injury that initiated	onsequence of):							
cecuted and rand ransit	- 1	d	3a,27,28		s mo c0	91 11	_21_1	1 cm		
760, ficate be executed physician and the burial - transi		FEMALE: 23c. If yes, or	itcome of pregnal		ше, дэ.	21 11	-21-1		23d. Date of de	elivery
D. Box 687 ithe death certific by the attending probed for use as the		b). Was decedent pregnant in the past 12 months? Yes 2 No 9 Unknown 9 Unknown	nt at time of death	_ =	I death 3 er (Specify)	Ectopio	c pregnancy		Month	Day Year
ires that the d signed by the lote detached by Physical by the lote detached by Physical by Physical lote by Physical lote by Physical lote by Physical lote by Physical lote by Physical lote lote lote lote lote lote lote lot	5	art II. Other significant conditions contributing to	leath but not resu	ulting in the un	derlying cause	given in Pa	art I.			ute to the cause of death? Probably 4 Unknown
cords law requestable to the second control of the second control	Para la la la la la la la la la la la la la						_	24a. Was a autops perfort 1 Yes 2	sy prid med? dea	ere autopsy findings available or to completion of cause of ath? Yes 2 No
fital Rec sician: The is certificate lirector, page	3 3	6. Was case referred to medical examiner? Hospital: 1 In	patient 2 Ef	R/Outpatient		of Death	(Check only		Residence 6	Other: Scene
on of Vision of the saing Physical Physical Control of the sain of	t	7. Manner of Death 28a. Date o		8b. Time of Inj	ury 28c. Inju	ry at Work	? 280		ow injury occurred	
Division of To the Hospital or Attending within 24 hours after death. To the Funeral Director: Aft completely filled in by the function of th		Accident Investigation	of Injury - At home	e, farm, street,	CIM		c. 28f	Location (S or Town, St arkvil	treet and Number (ate) 2401 At 1e, Md.	or Rural Route Number, City utumn View Way
To the Hosp within 24 ho To the Fune completely f	- 1 2	Ga. Certifier 1 Certifying Physician: To the best Deck only 2 Medical Examiner: On the basis of	examination and/				ace, and due	to the cause	e(s) and manner a	
N N N N N N N N N N N N N N N N N N N	2	and manner sta	70		29c. Licens O.C.		OCME		29d. Date signed October 10,	(Month, Day, Year)
	3	D. Name and address of person who completed cause Theodore M. King, Jr., MD. Assistan	o death (Item 23 t Medical Exa	•			eet. Balti	more. MD		
State Registra	e 3	·	strar's Signature	KN			,	-,		*****

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State Amend Item 25 State of Maryland 107099720 Files Health and Mental Hygiene 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ BEMTEMBER PLY9 2019 8:38A ALFRED FRANKLIN OWENS JR Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death FREDERICK 4b. City, Town, or Location of Death **Examiner** FREDERICK FREDERICK MEMORIAL HOSPITAL 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** (Month Day, Ye 1**X** M 2 □ F Days Hours 1927 229-26-7832 Virginia **Director** 83 Dec Jsual Residence of Decedent 23a or 28a-f show ist be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2X No Frederick MD Frederick 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21703 5024 Teen Barnes Road **Examiner must** or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1X Yes 2 ☐ No Black, White, etc. 1 Never Married 2 Married ò Maryland 21215-0036 1 Yes 2 No Specify: h and Mental Hygiene.
It is marked other than "natural", traumatic event, the Medical Exal If Yes, Give Specify: White Completed 3 Widowed 4 Divorced Year or Dates. 1945 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Grocery Store Owner Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Dennis Alfred Franklin Owens, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5024 Teen Barnes Rd. Frederick, MD 21703 27 Evelyn K. Owens/wife permit. Page 1 and 2 Department of Health Important: If item 21 any injury or other t. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2X Cremation 3 Removal from State Final Journey Crematory 09/23/11 Woodbine, MD 4 Donation 5 Other (Specify) 21. Signa ve of Funeral Service Licens Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph, sician/ Anoxic encepha LOPATHY disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner morrha vania Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) mor R that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of) CETTFICATION APPEALED BY SHE WITH EXAMINER attending physician for use as the burial Physician/Medical that the death certificate be Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Day Month signed by the at d be detached fo P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Division of Vital Records, or Attending Physician: The law requires 1 🗌 Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 2 No 1 Yes the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Z No Other: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred Certificate: Natural injury 5 Pending Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 2011 MOD 35106 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 745 Frederick, MD 2170 Myung Nam 400 W Hee

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

OCT 07

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2 0 | | | | | | | | | | |

		1- For State Registrar			C	ertific	ate of	Death			Re	g. No.		
Physic		1. Decedent's Nam	e (First, Midd	le,Last)		-				2	. Date of Deat	h		3. Time of Death
Medical Exam	ine	Dawn]	Lyn	Oliv	er					Month October 7,	Day 2011	Year	0435 hrs
		4a. Facility Name (1204 Ednor		on, give street and n	umber)		4	o. City, Town, o Silver Spri		of Death			ounty of Dea	
Funeral		5. Social Security N	lumber	6. Sex	7. Age (In yrs	s. last birt	thday)	If Under 1 Ye	ear If Und	er 24Hrs.	8. Date of Birt	th(MM/DD)/YYYY) 9. E	Birthplace (State or
Director		217-72-0		1 M 2XF	54		Yrs.	Months Da	ys Hour		Dec.		Fore	
any		Usual Residence of 10a. State	Decedent 10b. County		10c C	ity Town	or Locatio	n		-				10d. Inside City Limits
A	ğ	MD	Mont	gomery			or Educatio	Silve	r Spr	ing				1 Yes 2 No
the Mary	Director	10e. Street and Nu		l.				10f. Zip Code	0905		10		of What Co	•
th with cems 23s	Funeral	11. Marital Status 1 X Never Marrie		12. Was De	cedent Ever in			Decedent of H	lispanic Ori					erican Indian, Black,
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	by Fur	3 Widowed	4 Div	orced If Yes, Give Yes					o specify:		,	Sp		White
hours natur				cify only highest gra				Usual Occup				16b. Kind	d of Business	s/Industry
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212 Ild be Menta nark	To Be	19a. Informant's Na			OTIVE	•	Sr.	Address (Stre	,	ena		0.1	Dica	
MD 21215-0036 and 2 should be filed within 7 ulth and Mental lygiene. m 27 is marked other than aumatic event, the <u>Medica</u>		Ernest W	. 01iv	er, Jr./		r 1	204 E	dnor R	d., S:	ilver	Spring	g, MD	20	905
TOFE, ages 1 an at of Hea t: If ite			X Cremation	3 Removal fr	om State	cremate	ory or othe)ate		•	or Town, State
Baltimore, permit. Pages I an Department of Hea Important: If ite injury or other tri		4 Donation 5 21. Signature of Fur			Meo 3			Cremate and Address P Funet			4/2011		Beltsv:	ille, MD
		SWILL	100 VAS	man			-1.933	Gist /	Ave.	Silve	er Snri	ino.	MD	20910
Physician /Medical Examiner		23a. Part I, Enter the failure. List on! Immediate Cause (F	y one cause	complications that c on each line. a. Atherosclei					g, such as c	ardiac or re	spiratory arre	st, shock,	or heart	Approximate Interval Between Onset and Death
		or condition resulting		Due to (or as a	consequence	of):				_			-	
	niner	if any, leading to im- cause. Enter Under	mediate fying Cause	Due to (or as a	consequence	of):								
ted J unsit	Examiner	(Disease or injury the events resulting in contact the		Due to (or as a	consequence	of):								
3760, ficate be executed g physician and s the burial - transit	Physician/Medical	UNPENDED		AMENDED										
8760, ificate be ig physic	§	IF FEMALE: 23b. Was decedent p	regnant in th		outcome of pre							23d. D	ate of deliver	ry
certif anding ise as	Įġ.	past 12 months		I I Live b	irth ant at time of c	1 41.	\equiv		Ectopic	pregnancy	′	Mo	nth	Day Year
that the death certificated by the attending detached for use as:	hysic		o 9 🗹 Unk	nown 9 Unkno	wп	3		(Specify)	-					
8 50 e	δ	Part II. Other signifi	icant conditi	ons contributing to	death but not	resulting	in the und	lerlying cause	given in Pa	irt I.			contribute to	the cause of death?
ords, i	ete										24a. Was ar	n :	24b. Were a	utopsy findings available
Division of Vital Records, talor Attending Physician: The law requir rs after death. al Dire or. After this certificate has been sited in 1 y the funeral director, page 2 should the	Completed										autops	ned?	death?	completion of cause of
tal Rection: The certificate ector, page		25. Was case referre	ed to medical					26 Place	e of Death (Chack anly	1 Yes 2	No	1 🗸 Y	es 2 No
Vita hysician this cer	e Be	examiner?	-	Hospital:	npatient 2	FR/Ou	tpatient 3		I Othor -	Nursing H		acidonea	6 🗸 Othe	ar Coope
n of Vi ling Physi After this funeral dir	-1	1 ✓ Yes 2 27. Manner of Death		28a. Date (Month,			ime of Inju		ry at Work		d. Describe ho			. Ocene
ion tendin eath	텵	1 V Natural	5 Pend		Day,Year)			1 1	Yes 2	- 1				
rision of the control	E	2 Accident		igation28e. Place	of Injury - At I	home, far	m, street,	factory, office I	building, etc	c. 28f	f. Location (St	reet and N	Number or Ri	ural Route Number, City
Div spital or	Certification:	4 Homicide	deten	HOLDE					<u> </u>		or Town, Sta			,
Divis To the Hospital or At within 24 hours after d To the Funeral Director Completely filled in ty	edical	29a. Certifier 1 Coneck only 2	CertifyIng Ph Medical Exan	ysician: To the bes niner:On the basis of and manner st	f examination	dge, deat and/or in	h occurred vestigation	l at the time, d ı, in my opinior	ate and pla- n, death occ	ce, and due curred at the	e to the cause(e time, date ar	(s) and mand place,	anner as stat and due to th	ted. ne cause(s)
HSHÖ	¥ [29b. Signature and ti	tle of certifier		. ($\propto 1$		29c. Licens	se number			29d. Date	signed (Mo	onth, Day, Year)
		O Namo and add	M	ll l		7	7	O.C.	M.E.			Octobe	er 11, 201	1
		30. Name and addres Zabiullah Ali,	M.D. A	ssistant Medic	al Examine	r 900		timore Stre	et, Baltir	more, MI	D 21223			
Sta Regist	ate rar	31. Date of Month	4°2011	Densus 32. Re	gistrar Signal	Back	la d							
DHMH 17 Rev 1/20														OGME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ october 08:45AM 2011 Michael Paul Phillips Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Bel Air Harford Social Security Number If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Country) Baltimore **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Months Hours ^{Year} 1956 Dec. 24 **Director** 214-72-6384 Maryland show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked of ther than "natural", or items 23a or 28a-f sho important: If item 27 is marked of ther than "natural", or items 29a or 28a-f sho any injury or other traumatic event, the Madical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Harford Forest Hill 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2406 Putnam Road 21050 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. Armed Forces?
1 ☐ Yes 2 📉 No 1 Never Married 2 Married þ 1 Yes Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: Completed 3 Widowed 4 N Divorced Specify: White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) General Labor Home Repair Handyman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Howard Phillips Catherine Darnev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Stephen Phillips (Brother) 2128 Poteet Road, Forest Hill, Maryland 21050 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) October 14 4 Donation 5 Other (Specify) Highview Mem. Gardens Fallston, Maryland 2011 21. Signal Testerman Address Funeral Chapel & Cremation Services - Bel Air eeJeffrey R. (M01543) 3 Newport Drive, Forest Hill, Maryland 21050 23a. Part of the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a conseque (e of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or i that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy 5 Other (specify) ____ Month Dav Vear Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed or Attending Physician: The after death. 1 🗌 Yes Yes 2 25. Was case referred to medical examiner? the funeral director, Division of Vital Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 1No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate; 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation PHILLIPS, MICHAEL 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Cardifying Nurse Prantioner: To the best of my includedge disett d at the time, date and place, and due to the 29b. Signature and title of certifier D0066912 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TA PARSA, MID 510 UPPER CHESAREAKE DRIVE SLITE 409 BELAIR, MD 2104 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 12^{Day} Month 201°E 11:54 A M Benjamin Joseph Perry Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Baltimore Washington Medical Center Glen Burnie Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 XM 2 | F Hours 6-18-30 Year) 218-26-0755 Director MD Usual Residence of Decedent show 10a. State 10b. County with the Maryland 10c. City, Town or Location notified at 10d. Inside City Limits Director MD 28a-f Anne Arundel Glen Burnie 1 Yes 2X No 10e. Street and Number 10f. Zip Code ms 23a or r must be r 10g. Citizen of What Country? Funeral 7975 Crain Hwy. #116 21061 USA Pery / Senjanim 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Examiner Black, White, etc ò 1 X Never Married 2 Married þ 1 Yes 2 If Yes, Give Year or Dates. Baltimore, Maryland 21215-5036 1 ☐ Yes 2 X No Specify: Specify: white "natural" Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Anne Arundel County 8 Backhoe Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers is marked o 2 William Joshua Perry Sr. Anna Virginia Eagan permit. Page 1 and 2 st.
Department of Health an Important: If item 27 is m any injury or other. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7988 Quarterfield Rd, Severn MD 21144 Anna V. Greenway/niece 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 Burial 2 XCremation 3 Removal from State 10/13/11 Catonsville, MD Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) ignature Fune rvice Licensee 22. Name and Address of Facility Kirkley-Ruddick Funeral Home 421 Crain Hwy SE Glen Burnie MD 21061 M01364 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Acula disease or condition yeur once Medical resulting in death) Due to (or as a consequence of) Examiner new wa Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami Due to (or as a consequence of) resulting in death) Last physician a the burial-Physician/Medical that the death certificate be P.O. Box 68760 attending as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? ō Month Year Pregnant at time of death Day 2 No the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, To the Hospital or Attending Physician: The law requires 1 ☐ Yes 2 🗹 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed certificate 1 Yes 2 No Yes 2√ No æ 25. Was case referred to medica 26. Place of Death (Check only one) Hospita 1 Yes 2 No Other: ᅆ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) hours after death.

neral Director: After this afilled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident
Suicide Investigation М 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completed filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) lyor Madison Palle, Glen Durnie NUSAIREGI 31. Date filed (Month, Day, Year) 32. Registrar's State 4 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0 7.26+ tuber Medical Pacility Name (if hot institution; give street; and number) **Examiner** or Location of Deat 4c. County of Death 10 N/A ast birthday) 6. Se 8. Date of Birth (Month, Day,) Jan 25, 7. Age (In vrs. If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** . 1937 Hours West Virginia 285-34-1115 74 **Director** 1 🗆 M 2 🗶 F Usual Residence of Decede 28a-f show 10a. State the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director Maryland N/A Baltimore 1 X Yes 2 □ No 10e. Street and Number ŏ 10f. Zip Code 10g. Citizen of What Country? must be Funeral I items 23a 5030 Erdman Avenue 21205 USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔀 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Completed 3 XWidowed 4 ☐ Divorced Specify: White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Desk Clerk Motel Services Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Sam Wallace Margaret Ellen Alexander 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ashley Prunty (Grandaughter) 5030 Erdman Avenue, Baltimore, Maryland 21205 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Oak Lawn Cemetery 4 Donation 5 Other (Specify) 10/17/2011 Baltimore, Maryland 21. Signal de of Fundral State of notice of the Martin D. Lawson MITCHELL-WIEDEFELD FUNERAL HOME INC 6500 York Road, Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician Phelimonia disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) use as the burial-trar that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death signed by the at Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed director, page 2 should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 24 hours after death. Funeral Director; After this certificate ☐ Yes 2 No Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes 2 No ပ 1 MInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) completely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred M Natural 5 Pending work 1 Tyes 2 🗌 No Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examíner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the within 2 3 [Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 000 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Rrint) Grunber

Registrar

Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25,28a-f per me,g920_10/12/2011dhb Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month TONY 9:24 DM PASHKEVICH Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Medica La Center If Under 1 Year | If Under 24 Hrs 8. Date of Birth

1 0 - 1 3 - 1 9 2 8 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 € M 2 🗆 F Days Months Hours PA . Director 232-38-8129 82 Yrs Usual Residence of Decedent 28a-f show 10a. State 10h County injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MD. CHARLES COBB ISLAND 1 Yes 2 No 23a or 2 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15459 POTOMAC RIVER DRIVE 20625 U.S.A. or items 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces?

1 XYes 2 NdMARINES

If Yes, Give Year or Dates.1 9 4 6 – 4 8 þ 1 Never Married 2 Married should be filed within 72 hours aft and Mental Hygiene.

is marked other than "natural", 1 ☐ Yes 2 ▼ No Specify: 3√2 Widowed 4 □ Divorced Specify:WHITE Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) PILE DRIVER CAPITOL CRANE 12th Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ CONSTANTINE PASHKEVICH ANNA PATRONEK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is GARY PASHKEVICH-SON 702 SILVER LINDEN DR. LA PLATA, MD. 20646 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 XCremation 3 Removal from State Cemetery, General CREMATORY 9-2-11 ALEX., VA. 21. Signature of Fu Service Licensee 22 name and Address of Facility
RAYMOND FUNERAL SERVICE, P.A.
LA PLATA, MARYLAND 20646 M00479 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Ence nhals disease or condition Medical resulting in death) Due to (or designation a consequence of): Examiner Item a for Sequentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events CERTIFICATION APPROVED BY MEDICAL EXAMINER Examine Due to (or as a consequence of): 000000 and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical that the death certificate be IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? detached for Month Dav Year Yes 2 🗆 No the 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 Completed 3 ☐ Probably 4 ☐ Unknown 1 Yes Nο 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performen? Yes 2/11 No within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 No Division of Vital Hospital or Attending Physician: To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 X Yes Hospital: 2/1 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28b. Time of a. 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Ye 28c. Injury at 28d. Describe how injury occurred 1 🔲 Natural 5 Pending iniurv work?
1 Yes 2 No Subject ingested multiple medications. 08/23/2011 **Unknown**M 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of Rural Route Number City of Town, State) 15459 Potomac River Drive, Cobb Island, MD determined Home Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Praytioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cayse of death (Item 23a) (Type, Print) 5 ARR ENKINS 31. Date filed (Month, Day, Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year Physician/ 400 AM 2011 10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimor Rosedal HOSPITQ Quare Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months Days Hours Min M 2 🗆 F **Director** 212-50-6383 63 2/28/1948 Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location must be notified at Director **ESSEX** MD BALTIMORE 1 Yes 2 No 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5 ŪSA Completed by Funeral 23a 21221 1022 FOXRIDGE LANE Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify WHITE Specify. 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) BALTIMORE CITY INSPECTOR Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HELEN LACKEY မ EDWARD PARR, SR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number City or Town, State, Zio Code)
7414 ST. PATRICIA CT DUNDALK, MD 21222 CHARLES PARR-COUSIN 20b. Place of Disposition (Name of cemetery, crematory or other place)
MORELAND 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MD 10/15/11 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC 21, Signatu of Funeral Service License BALTIMORE, MD 21206 BELAIR_RD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) VENTROUM Medical Due to (or as a consequence of): Examiner C Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Exami Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown 1 Yes 2 L Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 X No 3 Probably 4 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of After this certificate has funeral director, page 2: autopsy death? performe 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examinar? 2 🗌 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Medical Certificate: 1 🔀 Natural 5 Pending 2 Accident
3 Suicide Investigation 24 hours after deatl Funeral Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) the within To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 12. 11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Hudson

801

OCT 1 4 2011

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Balto md

21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2011 32777 State of Maryland / Department of Health and Mental Hygiene

		- For State legistrar	Certificate of Death	Reg. No.	
Physicia	ın/	Decedent's Name (First, Middle,Last)		Date of Death Month Day	3. Time of Death
শ⊶dical Exami		Connie L. Paugh		October 9, 201	1 1232 1118
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location		c. County of Death
		6095 Majors Lane Apt. 2	Columbia		
Funeral		5. Social Security Number 6. Sex 7. Age	(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	nder 24Hrs. 8. Date of Birth (MM	/DD/YYYY) 9. Birthplace (State or Foreign
Director		017.72 9274 10M 2XF 5	3 Yrs.	Mug 18)	958 Country) MD
	Į	Usual Residence of Decedent	0c. City, Town or Location	<u> </u>	10d. Inside City Limits
w any		10a. State 10b. County	Oc. City, Town or Education		1 Yes 2 No
Maryland 28a-f show	ğ	IVID Howard	Columbia	10a Cit	izen of What Country?
th the Maryland 23a or 28a-f sho notified at once.	Director	10e, Street and Number	10f. Zip Code	Tog. Cit	I I S
th the		6095 IV ajors un 170	K. 2 1 21045	O de le O / O e self e Ven es No	14. Race - American Indian, Black,
th wit	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces?	If Yes, specify Cuban, Mexic	can, Puerto Rican, etc.)	White, etc.
or dea	ᇍ	1Yes 2	No 1 Yes 2 No spec	rifu.	Specify: Nit
rs afte ural" minel	ā	Widowed 4 Divorced If Yes, Give Yeer or Dates: 15. Decedent's Education (Specify only highest grade compared to the property of the prop			Kind of Business/Industry
2 hour	ted -	Elementary/Secondary (0-12) College (1-4 or 5-	during most of working life. DO N		
136 hin 7. than	ם	13	(Veck		ald hich
5-0036 iled within 77 Hygiene. I other than	Completed	17. Father's Name (First, Middle, Last)	18.Mo	ther's Name (First, Middle, Maider	n Surname)
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	Marenco Henry San	tain 1H	eko Naomi	Reale
	ျ	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and I	Number or Rural Route Number, C	City or Town, State, Zip Code)
		William Hough - Soon	se 10095/Vajors1	Ultof 3 Colin	mpig Modians
_ 2 % % 2		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from Stat	20b. Place of Disposition (Name of cemetery crematory or other place)	Date 20c.	Location - City of Town, State
Baltimore, permit. Pages 1 a Department of He Important: It its		A Donation 5 Other Specify:	Attantic Crews torce	1/0/13/11 14	lenturiu MP
Baltimo permit. Page Department of Important: injury or ott	1	21 8 gnature of Funeral Sérvice Licensee	22. Name and Address of Fa	dity Stack rune	rai Home, pa
E E G E	Å	MULLINIC DUNT-U	U1293 3871 ON 11 dur	nbic Piko Elli	COH City MO 21043
Physician		23a. Part L Enter the disease, or complications that caused t failure. List only one cause on each line.	he death. Do not enter the mode of dying, such a	as cardiac or respiratory arrest, sh	Delween Onset and
/Medical Examiner		Immediate Cause (Final disease a. Gunshot Wound			Death
		or condition resulting in death) Due to (or as a consec	quence of):		
	ᡖ	Sequentially list conditions, if any, leading to immediate Due to (or as a consecutive form)	quence of):		
	Examine	(Disease or injury that initiated			
st g	Ξį	events resulting in death) Last Due to (or as a conse	quence of):		
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60, ate be e ohysician e burial	Medical		- A management	22	3d. Date of delivery
876 ifficat ag ph		IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcom		topic pregnancy	Month Day Year
x 6 h cert tendir use a	is is	past 12 months?		291	
Bo e deat the at	Physician	1 Yes 2 No 9 Unknown 9 Unknown		D. 11 22a Did tohono	o use contribute to the cause of death?
that the death certificated by the attending detached for use as	by P	Part II. Other significant conditions contributing to death	but not resulting in the underlying cause given i	.,	✓ No 3 Probably 4 Unknown
S, P.C uires that n signed	g			24a. Was an	24b. Were autopsy findings available
ord w req us bee	plet			autopsy performed	prior to completion of cause of
Rec The la	Completed			1 Yes 2 ✓	
in: in:	BeC	25. Was case referred to medical examiner?		eath (Check only one)	C-2
Vit hysic this o	2	1 ✓ Yes 2 No			dence 6 Other: Scene
1 of ling P After funerz		27. Manner of Death 1 Natural 5 Pending FOUND:	y 28b. Time of Injury 28c. Injury at V ar) FOUND: 1 Yes 2	— Subject shot sell	
sior ttend death.	atic	Accident Investigation Oct 9, 2011	1220 hrs		and Number or Rural Route Number, City
Division of Vital Records, P.O. Box 687 tal or Attending Physician: The law requires that the death certific its after death. **I Director** After this certificate has been signed by the attending led in by the funeral director, page 2 should be detached for use as the content of the death of the state	Certification	Suicide Could not be	ury - At home, farm, street, factory, office buildin	or Town State)	Apt. 2, Columbia, MD
D spita hours neral fille		4 Homicide	ti-Family Apt.		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	g		knowledge, death occurred at the time, date an nination and/or investigation, in my opinion, deat	id place, and due to the cause(s) a th occurred at the time, date and p	place, and due to the cause(s)
Tot Within Totl	Medical	and manner stated. 29b Signature and title of certifier	29c, License num		d. Date signed (Month, Day, Year)
	-	6) H 5) H	O.C.M.E.		ctober 12, 2011
7		30. Name and address of person who completed cause of d			
*		Victor Weedn MD JD Assistant Medical		t, Baltimore, MD 21223	
-	tate		's Signature fauls		
S Regis		OCT 1 4 2011 Person	D. parker		

11-07635

eroy Pressley		State of Maryland / Departr			2011	32778					
			cate of Death		ـــ ـــ ـــ ـــــــــــــــــــــــــ	52110					
Physici Medical Exami		Decedent's Name (First, Middle,Last)		2. Date of Death Month October 9,	T	3. Time of Death 1343 hrs					
		4a. Facility Name (if not institution, give street and number) 4669 Falls Road	4b. City, Town, or Location of Dea Baltimore		4c. County of Death	-					
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last b		rs. 8. Date of Birth	(MM/DD/YYYY) 9. Birth	nplace (State or					
Director		247-50-2312 1 M 2 F 78 Usual Residence of Decedent	Yrs. Months Days Hours M	in. 10/14,	/1932 Foreign	ntry) SC					
any		10a. State 10b. County 10c. City, Tow	n or Location			10d. Inside City Limits					
faryland 28a-f show Latonce	ō	MD N/A	Baltimore			1 Yes 2 No					
th the Maryland 23a or 28a-f sho notified at once	Director	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Count	ry?					
ith th	ם	2315 Lauretta Avenue 11. Marital Status 12. Was Decedent Ever in U.S.	21223 13. Was Decedent of Hispanic Origin? (Procify Vos or No	U.S.A.	on Indian Black					
leath v	Funer	1 Never Married 2 Married Armed Forces?	If Yes, specify Cuban, Mexican, Puer		White, etc.	arr ingran, black,					
after o	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 No specify:		Specify: Bla	ck					
hours fratur Exam	leted I	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	 Decedent's Usual Occupation (Give kind o during most of working life. DO NOT use re 		6b. Kind of Business/In	dustry					
36 hin 72 than than	ple	12th Grade	Masonry		Self Employed						
5-00 led wit Hygien other	Comple	17. Father's Name (First, Middle, Last)		me (First, Middle, Maiden Surname)							
ID 21215-0036 should be filed within 72 hours after and Mental Hygiene. 77 is marked other than "natural", natic event, the Medical Examiner.	Be	Moochie Samuels	Gladys	The second secon	essley						
tie nd N	ဥ	19a. Informant's Name/Relationship (Type, Print) Bernette Pressley-Daughter 2		or Rural Route Number, City or Town, State, Zip Code)							
e, MC 1 and 2 st Health an Fitem 27		20a. Method of Disposition 20b. Place	·	20c. Location - City or T							
MOI Pages lent of unt: Il		1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: West	/15/11	Baltimor	e, MD						
Baltimore, MC permit. Pages I and 2 s Department of Health an Important: If item 27 injury or other traum.		21. Sur ature of Funeral Service Licensee	22 Name and Address of Eacility								
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do	Joseph H. Brow 2140 N. Fulton	Ave Ba	ltimore,	MD 21217 Approximate Interval					
/Medical	11.0	failure. List only one cause on each line.	th calcific coronary			Between Onset and Death					
xaminer		Immediate Cause (Final disease or condition resulting in death) a. Cardlomegaly will Due to (or as a consequence of):	th carciffic colonary	artery u	Isease						
	<u>_</u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):									
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated			528						
cuted ind transit		events resulting in death) Last Due to (or as a consequence of): d.									
a a a	an/Medical		27,per me,g921 11-21	1-11 sm							
760 ficate t g physi	/Me	IF FEMALE: 23b. Was decedent pregnant in the			23d. Date of delivery	V					
ecords, P.O. Box 68760, he law requires that the death certificate be take has been signed by the attending physiciage 2 should be detached for use as the buri	iciai	past 12 months?	2 Fetal death 3 Ectopic pregr 5 Other (Specify)	iancy	Month Da	y Year					
i, Bo the deal y the at	Physicia	1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting	ng in the underlying source given in Dort I	I 220 Did tobs	acco use contribute to the	o cause of death?					
ires that the signed by	ē	Cerebral infarct with seizures;			2 No 3 Proba						
cords, law requir has been s	etec			24a. Was an		ppsy findings available mpletion of cause of					
Reco The law icate has	Completed			autopsy performe 1 ✓ Yes 2							
tal Recison: The	Bec	25. Was case referred to medical examiner?	26.Place of Death (Check								
Physic rathis	2	O 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Sura'4 Nursing Home 5 Residence 6 V Other: See									
ion of tending Pt eath. tor: After t	ΞI	27. Manner of Death 28a. Date of Injury (Month, Day,Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Yes 2 No									
Division of Vital Records, and or Attending Physician: The law requires after death. In Director: After this certificate has been sited in by the funeral director, page 2 should be a possible of the funeral director, page 2 should be a possible of the funeral director, page 2 should be a possible of the funeral director, page 2 should be a possible of the funeral director, page 2 should be a possible of the funeral director, page 2 should be a possible of the funeral director.	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home,	farm, street, factory, office building, etc.	28f. Location (Stre or Town, Stat	eet and Number or Rura	I Route Number, City					
Dispital hours a filled		4 Homicide determined (Specify) 29a. Certifier		1							
Division To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.									
F > F 0	Ž	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mont	h, Day, Year)					
		30 Name and address of person the complete to the first file.	O.C.M.E.		October 13, 2011						
		 Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 900 N 	W. Baltimore Street, Baltimore, M	D 21223							
St	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature)								

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3:00 AM na to be 1a am Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Itimore ockeysuille Wa. ardington Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Year If Under 24 Hrs. **Funeral** 1 M M 2 □ F **Director** 76 TIMORE M 10d. Inside City Limits 28a-f show 10a. State 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 No MORE 10g. Citizen of What Country? 10e. Street and Number Funeral 21030 Was Decedent Ever in U.S Armed Forces? 1 Yes 2 KNo 14 Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 X No If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 Be permit. Page 1 and 2 should be filed. Department of Health and Mental Himportant: If item 27 is many injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, S., te, Zip Code) 19a. Informant's Name/Relationship (Type, P., ockous Vill nda 20a. Method of Disposition

1 Surial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State Date 4 ☐ Donation 5 ☐ Other (Specify) Moultan two 21/1/1 acility 16424 21. Signature of Funeral Service Licenses Chapela (eforation Approximate Interval Between Onset and Death ations that caused the death. Do not enter the mode of dying, such as cardiac o respiratory arrest Part 1. Enter the disease shock, or heart failure or compl astrointestina Immediate Cause (Filal Physician/ disease or condition Medical resulting in death) Due / (as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as the IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) signed by the at d be detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes plnods 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 has performed? 1 ☐ Yes 2 ☐ No 1 🗆 Yes 2 🗆 No certificate director. 25. Was case referred to medical 26. Place of Death (Check only one) Medical Certificate: To Be examiner? 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this of completely filled in by the funeral directors. 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred iniury Natural 5 Pending Investigation Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suiciae 4 ☐ Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 055197 MO

Registrar
DHMH 17 Rev 06-2011

State

Norman

31. Date filed (Month, Day,

OPPa

Road

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MB

Year

2360

W

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 5:05 AM Tulio Antonio Rebollo October 07 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Joseph Richey Hospice Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthdav) Social Security Number **Funeral** 1 🖾 M 2 □ F Months Days Hours (Month, Day, Year) 06/28/1929 Columbia 262-31-5557 Yrs Director 82 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 X Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 600 Light Street, Apt. 406 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Examiner Black, White, etc. ori þ 1 Never Married 2 X Married 1 Yes 2 No If Yes, Give Year or Dates. 1 Yes 2 No Specify. Specify. 'natural", 3 Widowed 4 Divorced Completed Latino Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) filed within 27 is marked other that traumatic event, the Heavy Equipment Operator Construction Be land 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental 2 Page 1 and 2 should be 1 ment of Health and Menta Tulia Rebollo Barrios 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 600 Light Street, Apt. 406, Baltimore, MD 21230 <u> Carmen Rebollo / Spouse</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Important: If it any injury or o once. 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) 10/12/2011 | Hanover, Maryland Anatomy Gifts Registry 21. Signature of F ral Service Licen 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ENDSTA Medical Examiner Sequentially list conditions. Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical use as the 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No for Year Month Day Pregnant at time of death the should be detached a I Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Records, Were autopsy findings available prior to completion of cause of 24a. Was an aw has autopsy page 2 death? Hospital or Attending Physician; The certificate 1 🗌 Yes Yes Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No 1 Tyes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Spec this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 2 Accident 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No s after death. Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined building, etc. (Specify) City or Town, State) 24 hours a Medical knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 Certifying Physician: To the best of my mination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical Examiner: On the basis of ex 3 Certifying Nurse Practioner: To the pest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2. To the F only one) 29b. Signature an 29d. Date signed (Month, Day, Year) 2011 10 30. Name and address of person why completed cause of death (Item 23a) (Type, Print) HOROWIT 31. Date filed (Month, Day, Year) State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death October Year Physician/ ROBIN 11:50 PM RANDLE 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A University of Maryland Medical Itamore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days Hours April 25 Country) Maryland 1 M 2 F 216-68-7305 54 **Director** Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10d. Inside City Limits 10a, State 10c. City, Town or Location **Funeral Director** 1 Yes 2 No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21201 733 West Saratoga Street 12. Was Decedent Eyer in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) **GNA** Nursing Home 11th Grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Elwin Furnell Smith Lorraine Bailey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 1614 West Saratoga Street Baltimore, MD. 21201 Charlene Randle - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 M Burial 2 Cremation 3 Removal from State 10/12/2011 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn, Maryland Woodlawn Cemetery Signature of Juneral Service Licenses 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Road Baltimore, MD. 21215 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ ative Grom rod NA Medical resulting in death) Due to (or as a condiquence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of): attending physician Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No jo Month Day Pregnant at time of death 5 Other (specify) signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? liver 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an stage page 2 s autopsy Hepatifis 1 ☐ Yes 2 🗷 No certificate funeral director, Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital _2 🔄 No ပ္ 1 Marient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 🔀 Natural 5 Pending Accident Investigation within 24 hours after death

To the Funeral Director. A

completed filled in by the f 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) , MD 6236482 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) South Street Baltmore 31. Date filed (Month, Day, War) Greene 32. Registrar's State 1 4 2011 OCT Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 | 32782 Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 07:19PM 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Deatl Mercy Medical Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) Yrs. If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Country) 1 □ M 2 € Months Director Usual Residence of Decedent show 10a. State Director event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 28a-f 1 Yes 2 □ No attimor 10e. Street and Numbe č 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 23a stree 2/2 items should be filed within 72 hours after death and Mental Hygiene.

is marked other than "natural", or items Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces?

1 Yes 2 1 No
If Yes, Give
Year or Dates. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No 3 Widowed 4 Divorced Blac 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname ၉ 1amin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21218 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau e950 Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place, 4 Donation 5 Other (Specify) Memoria Signature of Funeral Service 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Sepsis disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** weeks ecubitus Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) physician and s the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 attending ph IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Live Betal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 1 Yes 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Physician: The law autopsy performe death? 1 🗌 Yes 2 🗆 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \(\to \) Nursing Home 5 \(\to \) Residence 6 \(\to \) Other (Specify) 1 Tes 2 🗷 No မှ 1 Nation 2 ER/Outpatient 3 DOA After this 27. Manner of Deatl Certificate: 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af Accident
Suicide Investigation 1 Yes the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dong Paul Place 31. Date filed (Month, Day, Year) 32. Registrar's Signature 1 4 2011

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 6:26 AM **Physician** Helen Vivian Strennen October 13 2011 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Severna Park Anne Arundel 92 Riverside Drive 9. Birthplace (State or Foreign Country)
R.I. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 04/13/1926 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 🕱 F 038 14 5123 85 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, it is invided Example any injury or other traumatic event, it is invided Example. Severna Park 1 ☐ Yes 2 🕱 No Maryland Anne Arundel Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21146 U.S. 92 Riverside Drive Funeral 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) McCormicks Quality Control 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Davis Joseph Amaral 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Arlene M. Hardy / Daughter 2104 Folkstone Drive Fallston, Maryland 21047 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 10/17/2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 21. Signatur of Funeral Service Lo 22. Name and Address of Facility Gonce Funeral Service, P.A. Baltimore, Maryland 21225 4001 Ritchie Highway 23a. Part 1. Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** acute myocardial ing disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): physician and the burial-transi Due to (or as a consequence of): P.O. Box 68760, Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3

Ectopic pregnancy Month Year in the past 12 months? 4 ☐ Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown s been significant b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes 2 No spital or Attending Physician: The hours after death.
Ineral Director: After this certificate y filled in by the funeral director, pag 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Magner of Death 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral I completely filled Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier October 13, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar

16

Veterans Hwy,

3 Registrar's Signature

8601

mobit No

31. Date filed (Month, Day, Year)

millersville, md 2/108

State of Maryland / Department of Health and Mental Hygiene 20 32784 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Day Year Physician/ 255 AM Richard Swieczkowski 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Rosedale Baltimore FRANKLIN Square HUSPITal 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1**X** M 2 □ F Days Hours Min 215-76-1035 52 Yrs Director October 12,1958 Maryland Usual Residence of Decedent 28a-f shov 10b. County iral", or items 23a or 28a-f sho Examiner must be notified at 10a State 10c. City. Town or Location 10d. Inside City Limits with the Maryland Director Baltimore Md. Essex 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 618 Tampa Road 21221 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 XNo Specify: White item 27 is marked other than "natural", other traumatic event, the Medical Exal Specify 3 Widowed 4X Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working should be filed within 72. h and Mental Hygiene. 7 is marked other than "r life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Plumber Plumbing 12 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Anthony Swieczkowski Laverne Swieczkowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar. Important: If item 27 is a any injury or other traumonce. Joshua Swieczkowski Son 3437 Liberty Pkwy, Dundalk, Md. 21222 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State October cemetery, crematory or other place; 1 X Burial 2 Cremation 3 Removal from State Baltimore, Maryland Holy Rosary Cem. 4 Donation 5 Other (Specify) 17, 2011 Speature of Funeral S ervice Licen Name and Address of Facility
Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, book or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Due to (or as a consequence of): graft disease or condition Medical resulting in death) Examiner PVO (peripheral vascular disease) Severe Sequentially list conditions, Examine ir any, leading to immediate cause. Enter Underlying -transit vascular Cause (Disease or iinjury severe and that initiated events Due to (or as a consequence of): resulting in death) Last burialphysician the burial Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 attending ph 405 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Day Month Year Pregnant at time of death Unknown Yes 2 No the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy page performed' death? 2 No 1 Yes Yes 2 N within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica Be Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗌 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury To the Hospital or Attending 1 Natural 2 Accident 5 Pending From graft bleeding 0205 AM 1 🗌 Yes 2 No Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 21221 TAMPO ESSEK ma Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Gertifying Nurse Practioner: To the best of my knowledge, death one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 113 10 19011 D00 G1 G6 A 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 DR Jonathan FRANKLIN SQUARE DR Balto md 21237 L. Hanse 4 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygien Of Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Mero BER **Physician** 4.30 A. M E /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner EFEIL PEARY HEALTH CARE MARYLAND SYSTEM If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, O 8 / 1 1 / 0 8 / 1 1 / Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 61 Yrs. **Funeral** Months CA Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nert of Heath and Mental Hyglene.
Int: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, it. We don Ergin, that he multified at any or other traumatic event, it. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f show Prince George' MD Lanham 1 ☐ Yes 2 ☑ No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20706 7006 Dolphin Road by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Nayes 2 No Army If Yes, Give 970 - 72 Year or Dates: Never Married 2 Married White 1 Yes 2 □ No Specify: Mexican 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Equipment Technician Service Mother's Name (First, Middle, Maiden Surname) Helen Ramos 17. Father's Name (First, Middle, Last)
Joseph Spain Be ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1728 Waldorf Ct., Crofton, MD 21114 19a. Informant's Name/Relationship (Type. Print)
Joseph A. Spain Jr./Brother 20b. Place of Disposition (Name of Attempter, Frematory of Other Place) 10/12/2011 20c. Location - City or Town, State 20a. Method of Disposition Glen Burnie, MD 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Maryland Cremation Services PO Box 1413, Baltimore, MD 21. Signature of Funeral Service Licensee Dorota Marshall 11-outhor 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final disease or condition resulting in death) 5 **Physician** /Medical Due to (or as a consequence of): Examiner Metastatic Lung Cancer Se quentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? After this certificate has been signed funeral director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Tes 2 No 3 Probably 4 Munknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 🔼 No 1 ☐Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🕅 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident after death Director; 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D completely filled i 112 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State Registrar 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

VA MARYLAND 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year.

D0066032

HEALTH CARE SYSTEM, PEARY POINT, MA

October 10, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 23a per dr., 8920, Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death FR Month Physician/ 0255 AM 2011 10 Medical 4b City, Town, or Location of Death
Randallstown Baltimore **Examiner** 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Mg) 2 Day, 19129 M 2 | F Months Hours Director 28a-f show 10a. State 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 1 Yes 2 ☐ No MD10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code unit Funeral USA aurel ton Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Black If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retire) (Specify only highest grade completed) should be filed within 72 and Mental Hygiene. Elementa //Seconday (0-12) College (1-4 or 5+) he Be Father's Name (First, Middle, Last) ٩ permit. Page 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or come. smms 19a. Informant's Name/Relationship (Type, Print)

Darren D. Simms 19b. Mailing Address (Street ar State, Zip Code) 21214 Init E, Balto, and 62281 aurelton Zon Baltimore, Method of Disposition 20b. Place of Disposition (Name of cometery, crematory or other) matory or other place ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 10-13-11 4 Donation 5 Other (Specify) Bal 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final tai Ph. sician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate Examine cause. Enter Underlying Atherosclerotic Cardiovascular Disease Cause (Disease or linjury that initiated events resulting in death) Last The law requires that the death certificate be executed and -trar Due to (or as a consequence of) burialattending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Pregnant at time of death signed by the aid be detached to Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ₹ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performe 2 No certificate Yes 2 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medica 26. Place of Death (Check only one) Be topice simpatient unit examiner? Other: 2 **N** No 4 Nursing Home 5 Residence မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of injury (Month, Day, Year) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending Natural work? 2 🗆 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Sign 29c. License number 29d. Date signed (Month, Day, Year, 09

Registrar

DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

\(\int \) for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Dav Physician/ Medical Mark 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** uma If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 X M 2 D F (Month, Day, Year) 09/06/1957 Iowa Yrs. Director 54 177-50-1831 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified 1 X Yes 2 ☐ No Frederick MD Frederick 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? Funeral U.S.A. 2402 Shaker Lane 21702 items death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Medical Examiner Black, White, etc. 5 þ 1 Never Married 2 X Married within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: 'natural", 3 Widowed 4 Divorced Completed White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the Telecommunications 4 Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t, Page 1 and 2 should be file rtment of Health and Mental I rtant; If item 27 is marked o id Mental I ပ Marilyn Robinson Richard Wesley Spencer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2402 Shaker Lane, Frederick, MD 21702 Catherine Spencer / Spouse 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 10/12/2011 4 ☑ Donation 5 ☐ Other (Specity) Anatomy Gifts Registry Hanover, Maryland 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Fundal Service Lice 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or co shock, or heart failure. List only or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) X Sargunntion Medical Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or iinjury Use to for each consequence of CERTIFICATION APPROVED BY and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physiciar Physician/Medical certificate be Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Hospital or Attending Physician: The law requires that the death Day Pregnant at time of death 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 ☐ Yes 2 Ø No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No has page 2 certificate 1 ☐ Yes 2 📝 No Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: in 24 hours after death. in 24 hours after death. the Funeral Director. After this ce בוואם in by the funeral dire Other: 2 🗌 No ပ 1 Inpatient 2 KER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c, Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident injury work?
1 Yes 2 No 5 Pending 10-9-2011 Motorcy CLR Accidents

28f. Location Street and Number or Rural Route Number,
City or Town, State) Investigation 20.00 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined street Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2. only one) 29b. Signature and title of certifier 29c License number 29d. Date signed (Month, Day, Year) Oct 10, 2011 CA AIDY \$15 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

PATTHEN POWELL

SOUTH GREENE ST

BALTIMORE,

32788

			For State Registrar	State of M	aryland /		tment of F ificate of				gien e. (Reg. No.)	32100
	Physici /Medi		1. Decedent's Name (First, Middle AR BAR	dle, Last)	SHAL					Date of Dea Month	ath Day	O //	3. Time of Death 5 Pm M
an poly	Examir		4a. Facility Name (If not institution	on, give street and number,			4b. City, Town, o	r Location	of Death		4c. Co	unty of Death	J -
and the			106 Felton Roa	ad			Luther					ltimor	
	Funeral Director		5. Social Security Number 220-54-6721 Usual Residence of Decedent	6. Sex 7. Ag	ge (In yrs. last b		If Under 1 Year Months Days	Hours	Min	Date of Birt (Month, Da 04/09/	v. Year)	Cour	lace (State or Foreign itry) ryland
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	he M	ect		imore	Luth	ervi				—	10a Citizon	of What Cour	
	a or	Funeral Director	10e. Street and Number	3			10f. Zip Code	1			_	S.A.	iu y :
	ns 23	era	106 Felton Roa	12. Was Decedent	Ever in U.S.	13. Wa	21093		rigin? (Specify	Yes or No		Race - Americ	ean Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Ever it are continued at other.	þ	1 ☐ Never Married 2 🛣 Ma 3 ☐ Widowed 4 ☐ Divorce	Armed Forces? rried 1 □Yes 2 ☒ If Yes, Give	•		as Decedent of H 'es, specify Cuba ☐Yes 2 ☑ No	an, Mexica Specify		an, etc.)		Black, White, pec <i>ify:</i>	etc. sian
5-0	72 hc natur	etec	15. Decede	nt's Education est grade completed)	16	a. Decede	nt's Usual Occup	ation during mo	st of working		16b. Kind	of Business/In	dustry
21	ithin ne.	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		nd of work done NOT use retired	d)			78		
	led w dygiei her tl		47 Falls and Alama (First Adiabate	4		Arc	hitect	10 Moth	ner's Name (Fi	iret Middla	-	chitec	ture
Maryland	12 should be filed within h and Mental Hygiene. 7 Is marked other than traumatic event, 100 Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Mental Men	Be	17. Father's Name (First, Middle					Mar	_	role	Wonc		
2	should nd Me mark matic	မ	William Rick 19a. Informant's Name/Relation		19	b Mailing	Address (Street		1				Code)
Ma	and 2 s ealth ar n 27 Is ner trau		Alan Griffith				elton Ro						,
ē,	s 1 and 3 of Health item 27 other tr		20a. Method of Disposition		20b. Place		tion (Name of tory or other place		Date			tion - City or To	wn, State
Ë	Page nent o		1 ☐ Burial 2 ☐ Cremation 4 🛣 Donation 5 ☐ Other (1		ts Regist	i	10/13/	2011	Hanov	ær, Ma	ryland
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or ot once.		21. Signature of Funeral Service	e Licensee			Name and Addre					s Regis	
_	70 E # 9					75	22 Conne	elley	Dr.,	Ste. 1	P, Har	nover,	MD 21076
1	Physician /Medical Examiner	Je.	23a. Part 1. Enter the dislesse, shock, or heart failure. In mmediate Cause (final disease or condition resulting in death) Sequentially list conditions.	Due to (or as	a consequence	sys)	the mode of dyll	-	s cardiac or re	My Nen	1 - SOV)	Approximate Interval Between Onset and Death
90,	tificate be executed g physician and as the burial-transit	I Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	a consequence					·			
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O. Box	The law requires that the death certific ate has been signed by the attending prage 2 should be detached for use as:	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 poinths? 1 □ Yes 2 ŪNo 9 □ Unknown		of pregnancy 2 Fetal deat at time of death		Ectopic pregnand Other (specify) _	ру			230	d. Date of deliv	ery Day Year
rds, P.	w requires that been signed by should be deta	Ď	Part II. Other significant condit	cions contributing to death l	out not resulting	in the und	erlying cause giv	en in Part	I.	23e. Did t		/	he cause of death? bably 4 ☐ Unknown
of Vital Records,		Completed								24a. Was autoj perfo 1 ∐Yes		24b. Were auto prior to co death? 1 □ Yes	opsy findings available ompletion of cause of 2 \(\square\$ No
Vita	certific ector,	Be	25. Was case referred to medic examiner?				0.1		ce of Death (C	- 4			
of	Phys this al dii	2	1 Yes 2 No	Hospital: 1 ☐ Inpati 28a. Date of Inj	ent 2 ER/C	Outpatient Time of		4 L r			dence 6 [Other (Speci	fy)
	ding h. After funer	ion	27. Manner of Doath 1 Natural 5 ☐ Pendi	/A Annalo Di	ay, Year)	Injury	28c. Inju Wor M 1	ryan rk?]Yes 2.[. Describe	now injury o	ccureu	
Division	Hospital or Attending 24 hours after death. Funeral Director: After tely filled in by the funer	Certification:	3 Suicide 6 Could	not be 28e. Place of In	jury - At home, t tc. <i>(Specify)</i>	farm, stree		,,,,,		Location (Street and N wn, State)	Number or Rur	al Route Number,
	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in b	Medical C	29a. Certifier 1 Certify (Check only one) 2 Medica	ing Physician: To the besi Il Examiner: On the basis and manner s	of examination a	ge, death	occurred at the to estigation, in my	ime, date opinion, de	and place, and eath occurred	due to the at the time,	, date and pl	lace, and due	to the cause(s)
	To the within 2 To the compler	M	29b. Signature and title of certifi	er Llhyll	W		29c. Licens	se number	2411	0	29d. Date s	signed (Month)	Day, Year)
			30. Name and address of person address of person address of person address of person and address of person address	STA	death (Item 23a	(Type, Pi	CI	1	IMON	110	m	MD	21083
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		I- For State Registrar	Certificate of Death Reg. No.												
Physicia	an/	1. Decedent's Name (First, Middle,L	ast)	2. Date Mon	ne of Death										
^odical Exami	ner	Deve	Octo	October 10, 2011 2307 1118											
		4a. Facility Name (if not institution, University Hospital	give street and number)			City, Town, or L Baltimore	ocation of De	eath	4c. County of Death						
Funeral		Social Security Number 6.	Sex 7. Age (I	n yrs. last birtl	nday)	If Under 1 Year	If Under 24	Hrs. 8. Da	te of Birth(MM			(State or			
Director		213-43-3493	Z-M 2 F	7	Yrs.	Months Days	Hours	Min. 0	9-10-1	994	Foreign Country)	md.			
A		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 1													
nd shaw an	٦	and NA Baltimore									Yes 2 No				
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene. 27 is marked after than "natural", or items 23a nr 28a-f show matic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number	entalou s	st.		10f, Zip Code 2 / 2	-2-3		10g. Cit	tizen of Wha	-				
th with th cms 23a t be noti	Funeral [11. Marital Status 1 Never Married 2 Marr	12. Was Decedent Ev	er in U.S.		Decedent of Hisp , specify Cuban,	anic Origin?			14. Race - White,	American Inc	dian, Black,			
after dea	by Fur		1 Yes 2 V ed If Yes, Give Year or Dates:]	es 2 No				Specify:	Bla	R			
ours sami		15. Decedent's Education (Specify				Usual Occupation t of working life.			_	0	iness/Industry	y			
5-0036 led within 72 hours after Hygiene. In ther than "natural", the Medical Examiner	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) Ith Student 17. Father's Name (First, Middle, Last) College (1-4 or 5+) 18. Mother's Name (First, Middle, Maiden Surname)									sch	cools			
21215-0036 uld be filed within 7 Mental Hygiene. marked uther than		17. Father's Name (First, Middle, La	Singletar	SK	2	1		ame (First, I		Surname)	5				
21215-(uld be filed v Mental Hygi marked nth	o Be	19a, Informant's Name/Relationship	(Type, Print)	198	o. Mailing A	ddress (Street						ode)			
nore, MD 2121 ages 1 and 2 should be fi nt of Health and Mental it: If item 27 is marked inther traumatic event,		Latonya stage	15- mother	- 3	03	S. Ber	ntal	n S	+ · Ba	Uto in		4223			
ore, MC ss 1 and 2 s of Health au If item 27		20a. Method of Disposition 1 Burial 2 Cremation	3 Removal from State		of Dispositions ory or othe	on (Name of cem r place)	etery,	Date							
Page ment o		4 Donation 5 Other Spec			200	nce	m 1	0/18/	11 4	ansa	rine	, mD,			
Baltimore, permit Pages la Department of He Important: If ite		21. Signature of Funeral Service Lie	censee	/	22. Na	me and Address	of Facility	3405	Wil	2000	Klin	,21229			
	\dashv	23a Part I Enter the disease, or co	molications that caused the	death Dono	Na of enter the	mode of dving	such as cardi	ac or respira				proximate Interval			
Physician /Medical		failure. List only one cause or	each line.		t critor trio	mode programs,					Bet	tween Onset and Death			
Examinerے		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequ								_				
		Sequentially list conditions,	b								_				
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ansit		events resulting in death) Last Due to (or as a consequence of): d.													
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760, ficate be g physic ; the bur	ě	IF FEMALE:	23c. If yes, outcome	of pregnancy					2:	3d. Date of c	delivery				
687 ertific	an/	23b. Was decedent pregnant in the past 12 months?		e of death			egnancy		Day	Year					
Box 68 e death certification the attending	Physiciar	1 Yes 2 No 9 Unkno		ne of death	Othe	r (Specify)			- 1			31			
O. E at the c d by th		Part II. Other significant condition	s contributing to death b	ut not resulting	g in the un	derlying cause gi	ven in Part I.		Be. Did tobacco	_		_			
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TIII T	Be C	25. Was case referred to medical					of Death (Ch	eck only on	e)						
Vita hysici this c	.0	examiner? 1 Yes 2 No	Hospital: 1 Inpatient	2 ER/O	utpatient				e 5 Resid						
Division of Vital Records, talor Attending Physician: The law requir is after death. al Director: After this certificate has been seen is led in by the funeral director, page 2 should the funeral director, page 2 should	on: T	27. Manner of Death 1 Natural 5 Pendin	28a. Date of Injury (Month, Day, Year Oct 10, 2011		Time of Inj Ohrs	' '	yatWork? es 2.✔ No	Subje	escribe how in ect shot	njury occurre	ed				
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Cal Div	ŧ	3 Suicide 6 Could in determine determine Suicide		house / R	owhouse	e		1400 H	· Town, State) Kuper Place,	Baltimore	, MD				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the built		29a. Certifier 1 Certifying Phy	siclan: To the best of my k	nowledge, dea	ath occurre	ed at the time, da	te and place,	and due to	the cause(s) a	and manner place, and du	as stated. ue to the caus	se(s)			
To T	Medical	29b. Signature and title of certifier	and manner stated.			29c, License					ed (Month, D				
	-5	ill. A.	my (/ M)	>		O.C.N	Λ.E.		00	tober 11	, 2011				
PAN		30. Name and address of person w	ho completed cause of dea	o completed cause of death (Item 23a)											
0 0		Melissa Brassell, MD	Assistant Medical E		900 W.	Baltimore St	treet, Balt	imore, M	D 21223						
St Regis	ate	31. Date filed (Month, Day, Year) OCT 1 4 201	32. Registrar's	Signature	arke										
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 25 Sept 2011 Geraldine Smith Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A 1100 Pennsylvania Ave, Apt 1001 Baltimore Birthplace (State or Foreign Country) Social Security Number Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Days Hours 104-30-3014 Director 1 □ M 2 😾 F 73 09/20/1938 N. Carolina Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c City Town or Location event, the Medical Examiner must be notified at Director N/A 1 XYes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 1100 Pennsylvania Avenue, U.S.A. 21201 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces? "natural", or à 1 屎 Never Married 2 🗌 Married permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Importants if fleen 27 is marked other than "natural", or any injuy or other traumatic event, the Medical Examinant in th Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 Widowed 4 Divorced Black Completed 15. Decedent's Education 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Crownsville Hosp. Years unknown 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) McFadden Ruth Levy Duren 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3509 Holmes Ave, Baltimore, MD 21217 Mamie Duren (StepMother) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) On-Site Cremation: 10/12/11 Baltimore, 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition ardio Dusi resulting in death) Medical Due to (or as a consequence of): Examiner DENTENSI Sequentially list conditions, Examine It any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. • Funeral Director: After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☑ No Month Year Dav Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by (UA 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Smoke autopsy performed⁴ 1 Yes 2 No Yes 2 L 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 Yes 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work?
1 Yes 2 No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending Accident Investigation 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the F only one 29d. Date signed (Month, Day, Year)

State Registrar 29b. Signature and title of certifie

OCT 1 4 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 2. Registrar's Sign ひつかイケア

419 WRedwood St Bilt N.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 3/50 M WENDY LYNN TORMOLLAN Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death psedale Hospital Balhmore Square Center cial Security Number If Under 24 Hrs. 7. Age (In vrs. last birthday) If Unde 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 😿 F Months Days Hours 4-10-1967 218-94-5263 44 MARYLAND Director Usual Residence of Decedent 28a-f show Director 10a. State 10d. Inside City Limits aţ 10c. City. Town or Location notified MD BALTIMORE **ESSEX** 1 ☐ Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ò must be Funeral items 23a 605 DUNWICH WAY 21221 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11 Marital Status the Medical Examiner Armed Forces?

1 Yes 2 No Black, White, etc. 9 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 XNo Specify: Specify: WHITE "natural", Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) WAITRESS RESTAURANT permit. Page 1 and 2 should be filed wir Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, the once. traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ **JAMES** BRISSEY RITA DENNIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21040 JESSICA KUCZINSKI/DAUGHTER 1202 PAUL MARTIN DRIVE EDGEWOOD, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2X Cremation 3 Removal from State METRO CREMATORY 10-11-11 CATONSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21237 T211 CHESACO AVE ROSEDALE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Hemorrhagic disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine -transit Cause (Disease or linjury that initiated events resulting in death) Last (or as a consequence of Physician/Medical Box 68760 ed by the arending prodetached for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Month Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an Hospital or Attending Physician: The law autopsy performe page 2 Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital è 2 No 1 Yes 1 Impatient 2 I ER/Outpatient 3 I DOA this 28a. Date of injury (Month, Day, Year) funeral 27. Manner Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 \square Pending work? 1 Yes 2 No 24 hours after death. Funeral Director: A ☐ Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🛘 within 2 To the P only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year) 8 2011 2/237 Name and address of person who completed cause of death (Item 23a) (Type, Print) guare Drive State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20For State Registrar 32792 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Miriam R. Taylor 2011 October **p**.M 3**:3**0 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Hospice Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Hours Min. 213-32-8783 7-5-1935 Country) Director 1 □ M 2√□ F 76 MD show th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 📈No MD Anne Arundel Seven 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1823 Meade Village Circle USA 211//.

13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) within 72 hours after death Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. ģ 1 X Never Married 2 ☐ Married 2 X No ☐ Yes Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: African-American Completed 3 - Widowed 4 - Divorced 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Hospice Center Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William M. Taylor Geneva Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 2121 Windsor Garden Lane, Apt. 306A, Baltimore, MD21207 Herman Taylor/ Brother injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or oth 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Lorraine Park 10/12/2011 Baltimore, MD 21. Signature of Funera rvice 22. Name and Address of Facility Wile Juneral Home P.A. of Paltimore Co. 9200 Liberty Road, Randallstown, MD 21133 23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ lebili LOVE disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exam To the Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innerial director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Year Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ COMCEZ, Records, 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Tes 2 No 2 No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tyes မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 7. Manner of De th Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending Accident Suicide 1 Yes 2 🔲 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifiei Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year)

CTOSEA 3 20// 29b. Signaty d title of certifier address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Michael Frederick Toomey II 2011 8:26 A October Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford 3482 Albantowne Way Edgewood If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Davs Hours 1 ☑ M 2 □ F 1994 Maryland **Director** 217-41-5882 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Marvland | Harford Edgewood 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 3482 Albantowne Way 21040 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes Give Specify. 3 Divorced 4 Divorced White Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) High School 12 Student Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Pamela Marie Yingling Michael Frederick Toomey Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 3482 Albantowne Way, Edgewood, Maryland 21040 Pamela M. Yingling / Mother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp: 10-17-2011 Towson, Maryland of Fune Service Lie 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 k caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. 23a. Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner oselval Cary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death 5 Other (specify) signed by the signed for detached for the signed fo Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an 24 hours after death.

Funeral Director: After this certificate has performed 2 No 1 Ves 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) funeral Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1. Natural 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Menchs - Pedratrician October 11, 2011 D0056807 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CORAZON P. SANCHEZ, MO 4863 Pulaski Hwy. St. 120 Perryville, MD 21903 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 4 2011 Registrar

recory toles Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unk Unk State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 3. Time of Death Month Day September 25, 2011 0400 hrs Medical Examiner Gregory Leon Toles 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 3925 Dolfield Avenue Baltimore N/A7. Age (In yrs. last birthday) If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year Funeral 5. Social Security Number 4 30 Months Hours June 11,198 or wary land Director 1 → M 2 F Usual Residence of Decedent шy 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits N/A Baltimore Maryland 1 XYes 2 No Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygene.
rant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other trannatic event, the Medical Examiner must be notified at once Director 10e. Street and Number 10g. Citizen of What Country? 3828 Boarman Avenue USA Funera 11 Marital Status Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 2 X No Yes _{Specify}Black 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: tem 27 is marked other than "natural", traumatic event, the Medical Examiner 2 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) Unemployed Year Baltimore, MD 21215-0036 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Sharon Griffin Gregory Toles Be 19b. Mailing Address (Street and Number or Bural Route Number, City of Town State Zip God 21215 828 Boarmen Ave Baltimore, Mary Tand 19a. Informant's Name/Relationship (Type, Print) ဥ Sharon Peterson/ Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place)
King Memorial Park 1 X Burial 2 Cremation 3 Removal from State Woodlawn, Maryland 10 - 1 - 114 Donation 5 Other Specify. 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, MD 21215 21. Sign we of Funeral Service Licensee isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line. Between Onset and /Mudical Death a Multiple Gunshot Wounds Immediate Cause (Final disease ≟xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED attending physician or use as the burial Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the 3 Ectopic pregnancy 2 Fetal death Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown page 2 should be Completed certificate has been 24b. Were autopsy findings available 24a, Was an prior to completion of cause of autopsy performed? death? ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical of Vital 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗸 Other: Scene this 1 🗸 Yes After t funeral 28a. Date of Injury (Month, Day, Year) FOUND: 27. Manner of Death 28b. Time of Injury 8c. Injury at Work? 28d. Describe how injury occurred **FOUND** Division Natural 1 Yes 2 ✔ No Director: Pending 24 hours after death. Funeral Director: Sep 25, 2011 2 Accident 0350 hrs Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) 3925 Dolfield Avenue, Baltimore, MD determined (Specify) Local Street 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ine hi O.C.M.E. September 25, 2011 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Ling Li, MD 31. Date filed (Month, Day, Year) Registrar's Signatur State Registra 4

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death ededent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 5:30 PM Medical 201 Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death If Unde 9. Birthplace (St **Funeral** Months Hours Country) Director 28a-f show 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director Yes 2 No Citizen of What Country? Funeral 701 a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. Race - American Indian Armed Force by Black, White, etc. 1 Never Married 2 Married 2 No Yes Baltimore, Maryland 21215-0036 No. If Yes, Give 1 Yes Specify. marked other than "natural", 3 Widowed 4 ☐ Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) DO_NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be Father's Name (First, Middle, Last) Mother's Name (First, Mide ဂ္ ame/Relationship (Type, Print) 0a. Method of Disposition 20b. Place of Disposition (Name of City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 7/2/7 21. Signature tve. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Year Month Pregnant at time of death 5 Other (specify) Dav been signed by the s should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed completed filled in by the funeral director, page 2 1 Yes 2 No 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) Hospital: Other 1 Tes 2 No 은 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 24 hours after deat Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Contributing hurse Praction or To the gas of my in collection occurred at the time, date and place, and due to the cause (s) and manner as stated. (Check within 2 To the I only one the 29b. Signature and title P 29c. License number 29d. Date signed (Month, Dav. Year)

Registrar
DHMH 17 Rev 7/2009

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State

32. Registrar's Signature

30. Name and address of person who completed ause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

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	Division of Vital Re	within 24 hours after death. To the Funeral Director: After completed filled in by the fun	Medical	29a. Certifier 1 **Certifying Physician: To the best of Check only one) 3 **Certifying Nurse Practioner: To the	examination an	nd/or ir	nvestigation, in my opinio	n, death occurred at t	he time, date and	place, and due to the c	ause(s) and manner stated.			
4	Tot	To t		29b. Signature and title of certifier Yaua Quuo M	D		29c. License	number 32744	29	Detailed (Month)	Day, Year)			
	10	+11		30. When and address of person ho completed cause of AN RA MD	death (Item 23)	a) (Typ	De, Print) Hayortal	DV G	len B	unie)	ip			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ OCTOBER ^D**3**^y 1 RAYMOND VAUGHN ŽÕ11 Μ. 11:55PM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death BALTIMORE 11630 GLEN ARM ROAD APT 102 GLEN ARM ^{5.}239\$36¥0548 212-37-0548 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** CAROLINA 4-19-1928 1 **X**M 2 □ F Days 83 **Director** Usual Residence of Decedent 28a-f shov 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director BALTIMORE MD GLEN ARM 1 🗆 Yes 2 🔀 No 10e. Street and Number 10g. Citizen of What Country? ò 10f. Zip Code rral", or items 23a or Examiner must be Funeral 11630 GLEN ARM ROAD APT 102 21057 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ♣ Yes 2 □ No If Yes, Give Year or Dates. 1951 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE 3 🕅 Widowed 4 🗆 Divorced Completed 1951 the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) AIR FORCE MILITARY traumatic event, Be 7. Father's Name (First, Middle, Last)
CHARLIE JAKE 18. Mother's Name (First, Middle, Maiden Sumame)
CARRIE MAE (HALL and Mental Fishers of VAUGHN permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) SHARON E. KELLEY/DAUGHTER 11406 MANOR ROAD GLEN ARM, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Nother (Specify) ENIONEMENT PARKVILLE, MARYLAND MORELAND MEMORIAL PARK 10-15-2011 22. Name and Address of Facility CVACH/ROEDALE FUNERAL HOME 1211 CHESACO AVEINUE ROSEDALE, MARYLAND 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 2 6 wan flus. Immediate Cause (Final Ph_sician/ tancreatic disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events Due to (or as a consequence of): sician and burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last physician s the burial Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 32798 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Patsy A. Wood Medical 2011 Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Mico 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🕱 F Director 07/14/1935 Country) 219 30 6758 76 Maryland Usual Residence of Decedent 28a-f shov or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits Maryland Dorchester Cambridge 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5407 Peachtree Road U.S. 21613 Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married M+S / M00 /Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates 1 ☐ Yes 2 🕱 No Specify: Completed 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) and Mental Hygiene, is marked other tha Welfare Investigation State of Maryland years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ John Schilpp Audrey Ernest 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Holly Zeinog / Niece 5407 Peachtree Road Cambridge, Maryland 21613 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1

Burial 2

Cremation 3

Removal from State 10/12/2011 4 Donation 5 Other (Specify) Bayview Crematory Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 Part 1. Enter the disease, of emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Disperts disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) attending physician and for use as the burial-transit Exami that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy Pregnant at time of death Month □ No Yes 1 L Yes 2 L 9 L Unknown s been signed by the should be detached Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24a. Was an 24b. Were autopsy findings available this certificate has prior to completion of cause of death?
1 □ Yes 2 □ No autopsy performed funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 Yes tospica မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Funeral Director: After sted filled in by the funer Natural 5 Pending work? 1 ☐ Yes 2 ☐ No death. Accident Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one 29b. Signatur 2 d title of certifier 29d. Date signed (Month, Day, Year, and address of person who completed cause of death (Item 23a) (Type, Print) WAGA PO

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death SEP 22 2011 Physician/ 7:01 P M YUKIRA AALYIAH WALKER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death MONTGOMERY BETHESDA WRNMMC If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, Social Security Number 6. Sex 8. Date of Birth **Funeral** Min Days 1 M 2 X F 9^M22-20^Y1 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director MD Anne Arundel Severn 1 ☐ Yes 2 🛣 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21144 7941 Bent Bough Road USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. ģ 1 X Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: Black 3 🗌 Widowed 4 🗎 Divorced Completed Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 Is and Mental Hygiene.
7 is marked other than "n Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Marion Andre Walker Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important; If item 27 is any injury or other trau 7941 Bent Bough Road, Severn, MD 21144 Andre Walker/father 20a. Method of Disposition
1 □ Burial 2 ☒ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Catonsville MD 21. Sign were of Funeral Serv 22. Name and Address of Facility Kirkley-Ruddick Funeral Home 421 Crain Hwy SE Glen Burnie MD 21061 disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part 1 Enter the shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ EXTREME PREMATURITY disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Exami Cause (Disease or iinjury that initiated events resulting in death) Last the Hospital or Attending Physician; The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): physician Physician/Medical P.O. Box 68760 the attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month Day Year Unknown signed by the detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>a</u> Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? death? he Funeral Director: After this certificate I pleted filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ▼ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 🗌 Yes 2 🔀 No မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 XInpatient 2 - ER/Outpatient 3 - DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural Accident 5 Pending injury 1 ☐ Yes 2 ☐ No after death Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2

To the I

comple only one) 29b. Signature and title of certified 29c. License number D54927 Sept 23, 2011

DHMH 17 Rev 7/2009

State Registrar parke

WRNMMC

BETHESDA MD 20889-5600

n who completed cause of death (Item 23a) (Type, Print) $\stackrel{\cap}{\operatorname{CAPT}}\stackrel{\cap}{\operatorname{MC}}\stackrel{\cup}{\operatorname{USN}}$

32. Registrar's Signature

d address of person w CURTIS C

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JOHN EDWIN WISE, SR. OCTOBER 8 2011 Year 5:30 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5501 KATHRYNS COURT BALTIMORE WHITE MARSH If Under 1 Year If Under 24 Hrs **Funeral** Social Security Number 6. Sex 1 ★M 2 ☐ F 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign Days 217-26-8645 Hours 4-M75-1930 **Director** 81 Yrs MD Usual Residence of Decedent ortant. If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD BALTIMORE WHITE MARSH 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5501 KATHRYNS COURT 21162 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ✓ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian . o. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", 3 Widowed 4 Divorced WHITE Year or Dates. 1963 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) ELECTRICIAN BETHLEHAM STEEL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည **EDWARD** WISE THELMA THEIS 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, ROSALIE WISE/WIFE 5501 KATHRYNS COURT WHITE MARSH, MD 21162 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) FINDMENT CARDENS OF FAITH CEMETERY: 10-12-2011 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE ROSEDALE, MD 21237 23a. rart 1. Enter the disease, r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death luic Physician/ Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin sician and burial-transit Cause (Disease or linjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): ending physician a ruse as the burial-Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 1 L Yes 2 L g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? 25. Was case referred to medica sompleted filled in by the funeral director Be 26. Place of Death (Check only one) 2 XNo Other: 1 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a To the Funeral I Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D37612 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5430 Campbell Blud, white Marsh MD21162

Registrar DHMH 17 Rev 7/2009

State

Mohamad 31. Date filed (Month, Day, Year)

Box 68760

P.O.

Records,

of Vital

Division

Alabrash, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 3280 Certificate of Death cedent's Name (First, Middle, Last 2. Date of Death 3. Time of Death Physician/ OCTODOS 10 2011 6:25A Medical 4a. Facility Name (if not institution City, Town, or Location of Death Examiner give street and number 4c. County of Death N/A If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign Sex 7. Age In vrs. last birthday) **Funeral** Hours Mi 4 – 8 – 1943 219-40-1828 MARYLAND **Director** 1 □ M 2 🔀 F 68 Yrs. or 28a-f show notified at 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits Director MD N/A BALTIMORE CITY 1 X Yes 2 □ No 10e. Street and Number 2 should be filed within remember and Mental Hygiene.
27 is marked other than "natural", or items 23a or an event, the Medical Examiner must be remember. 10f. Zip Code 10g. Citizen of What Country? Funeral 5062 WRIGHT AVENUE 21205 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☒️No If Yes, Give Year or Dates. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: Specify: WHITE 3X Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 8 SECURITY GUARD BALTIMORE CITY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev မ JOHN HARVATH RHODES J. PEARL E. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CASTELL COURT NOTTINGHAM. JAMES W. WOLF, JR./SON MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 1

Burial 2

Cremation 3

Removal from State METRO CREMATORY 11-13-2011 CATONSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funcio Service Lice see 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21237 1211 CHESACO AVE ROSEDALE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Ph_sician/ CLOSTRIDIUM DIFFILILE disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Litter underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last burialphysician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death ed by the a 9 Unknown 9 Unknown s been signed by to should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 📈 No 3 ☐ Probably 4 ☐ Unknown Completed . Were autopsy findings available prior to completion of cause of 24a. Was an Jas autopsy perform death? 1 Yes 2 No certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No မ 1 Ves 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) eral Director: After this filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🛛 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral C

completely filled Medical 1 ី Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of co 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 06-2011

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRIM

MATTHEW 31. Date filed (Month, Pay, Year) RES-000

OCTOBER 11, 2011

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,, t				1 - State Registrar 1. Decedent's Name (F)			g,20,10	Cer	tificate of	Death			Reg. No.			32802	
Windham		Physicia Medi		Mary Fra	ances V	Vindham						2. Date of Deadler			Year	3. Time of Death	
ndi	9	Exami	ner	4a. Facility Name (if not Sinai Ho	- \	C () A	timore	,	4b. City, Town, o	or Location		1.7		Ocunty o	f Death		
		Funeral Director		5. Social Security Number 243-50-1	976 6. Se		Age (In yrs. lasi		If Under 1 Year Months Days	If Under	24 Hrs. (8. Nate of Birt Month, Da 3 / 8 / 3	th y, Year)		9. Birthpl Count N	lace (State or Foreign	
ncs		aryland a-f shov fied at	ctor		b. County N/A		10c, City, Ba.	Town or Loc	ation re			_			10	0d. Inside City Limits 1 Yes 2 No	
Frances		with the Ma s 23a or 28e ust be notif	Funeral Director	10e. Street and Number		on Ave			10f. Zip Code 21	215			10g. Citi	izen of W	at Count		
Known aw"Mary	9800	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status 1		12. Was Deceden Armed Forces 1 Yes 2 If Yes, Give Year or Dates.	t Ever in U.S.	l If	das Decedent of H Yes, specify Cub ☐ Yes 2 🔀 No	an, Mexicar	n, Puerto Ri	fy Yes or No- can, etc.)		14. Race - Black, Specify:	America White, e Afr Ame	ican	
1 000 h	Maryland 21215-0036	within 72 ho giene. er than "nat the Medica	Completed by		5. Decedent's Ed only highest grad rry (0-12)		life DO NOT was mating all						ing Hosp:				
Know	yland	ild be filed v Mental Hyg narked oth	To Be	17. Father's Name (First Junius W.	illiam	ams Betsy F						(First, Middle, Maiden Surname) arrison					
B		id 2 shou ealth and n 27 is m er traum	1	19a. Informant's Name/ Ethel Sta	Relationship (Typanley/I	oe, Print) Daughte	r i	19b. Mailing 2 7 2 2	W. Gar	and Number	er or Bural F N AV	Balt.	, CitMD	Town Sta	21 ^{zig Co}	ode)	
	Baltimore,	Page 1 an tment of He tant: If iten jury or oth		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of Cemetery, crematory or other place) Western Cem.													
	Bal	permil Depar Impor any in	12	21. Signature of Furleral Servic License 22. Name and Address of Facility Hari P. Close F. Svs. PA 5126 Belair Rd, Balt., MD 21206-5105											05 ^{PA}		
	~	Physician/ Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a													
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W	092	cate be exe physician a s the burial-	ical	resulting in death) Last	L,	Due to (or as	s a consequen	ce of):		CERT	TIFICATION						
Textorne	. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate in within 24 Jours after death. With In 14 Jours after death. The Funeral Director. After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 1 Unknown 23c. If yes, outcome of pregnancy 23d. Date of delivery 23d. Date									*				
上は	ds, P.0	requires that t been signed b should be deta	ed by Pl	Part II. Other significan	t conditions cor	ntributing to death	but not resulti	ng in the un	derlying cause gi	iven in Part I	l.					cause of death?	
320	Secor	The law req ate has bee page 2 sho	omplet									24a. Was a autop	sy med?	prid dea	or to com ath?	sy findings available upletion of cause of	
C++	ital F	sician: T certifica lirector, p	Be	25. Was case referred to examiner?	н	ospital:				lace of Deat						No	
	of V	ing Phy:tter this iuneral d	ate: To	27. Manner of Death	☐ Pending	1 A Inpa 28a. Date of inj (Month, Da	tient 2 ER ury 28 ay, Year) 28	Outpatient b. Time of injury	3 LJ DOA 28c. Injury	y at k?	280	5 Resid			Specify)		
	Division of Vital Reco	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director After this certific completely filled in by the funeral director,	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be determined								28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	_	To the Hospita within 24 hours To the Funeral completely filled	Medical	(Check 2 🔲 N	Medical Examine	cian: To the best of er: On the basis of Practitioner: To the	examination an	d/or investig	ation, in my opinio	on, death oc	curred at the	e time, date ar	nd place,	and due to	the caus	e(s) and manner stated	
4		To the within comp		29b. Signature and title of		with A	HAP	inowicage, a	29c. License		7	1	29d. Date	e signed (A	∕lonth, Da		
10				30. Name and address of Lauren Smith		mpleted cause of a	death (Item 23	a) (Type, Pri	nt)	دلا ولم	2.1				,		
W		Stat Registra	_	31. Date filed (Month, Da	y, Year)	33 Registr	rar's Signature	vealle	Ave - S	12	-, In	THAIDIT	- 17	U OH	CW		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2 [] Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 10 Physician/ 0912AM Medical 4c. County of Death **Examiner** Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 82 Director 28a-f show 10d. Inside City Limits must be notified at Director 42018 1 Yes 2 No 10g. Citizen of What Country 10f. Zip Code ò Funeral 23a LICIO-0036

Lice 13-0036

Department of Health and Mental Hygiene.
Important: If item 27 is marked others any injury or others. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U. 11. Marital Status Armed Forces?

Yes 2 No Black, White, etc. 1 Never Married 2 ☐ Married þ Yes, Give No Specify 3 Widowed 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Be 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Marie 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State oakrison 5// ladelphia, Blud. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final cause 1 Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Physician/Medical Examiner Due to or as a consequence of cause. Enter Underlying ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Medical Certificate: To Be 1 Yes 2 No ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient After this 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1
Yes Manner of Death 28b. Time of 28d. Describe how injury occurred injury 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Af Investigation Accident Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 3 🗆 only one) ature and title of cert 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Run 7D

DHMH 17 Rev 06-2011

Registrar

4 2011

Certificate of Death

2. Date of Death

Month

9^{Day}

2011

14. Race - American Indian

Black, White, etc.

Specify

12:49 p

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

90 min.

Day

24b. Were autopsy findings available prior to completion of cause of death?

1

or 2 □ No

Year

23d. Date of delivery

Month

1 ☐ Yes 2√☐ No

1. Decedent's Name (First, Middle, Last)

Physician

State Registrar

Day, Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #19a Per FH G920 10/25/2011 JH. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Richard Linwood Williams Oct 6, 2011 7:24 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Howard Columbia **Brighton Gardens Assisted Living** 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months Hours Min. (Month, Day, Year) Feb 7, 1933 Country) 228-36-0296 Director VA Usual Residence of Decedent or 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Howard Columbia 1 Yes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 23a Funeral U.S.A. 9256 Broken Timber Way 21045 items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces?

1 X Yes 2 If Yes, Give Black, White, etc 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Completed by 2 🗌 No Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: Korean Specify: 3 ₩ Widowed 4 □ Divorced Year or Dates. any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Engineer Engineering Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Hersey Linwood Williams Helen W. Williams 19Robern's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Linwood Williams Son 9256 Broken Timber Way Columbia, MD 21045 20b. Place of Disposition (Name of cemetery, crematory or other place)

Sherwood Memorial Park 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Oct 10, 2011 Salem, VA 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043 of Funeral Servi +1001293 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause Interval Between Onset and Death n each line Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death signed by the a Yes 2 No 9 🗆 Unknown 9 Unknown Division of Vital Records, P.O. Part I. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed filled in by the funeral director, page 2 should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy perform death? 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No ျ 4 ☐ Nursing Home 5 ☐ Residence 6 🗷 Other (Specify) 1 Inpatient 2 I ER/Outpatient 3 I DOA After this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 🗌 Yes 2 🗌 No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c, License number mD

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State

1

30. Name and address of person who completed cause of death (Item 23a) (Type, Pr

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death **Anne Arundel Medical Center Anne Arundel County Annapolis** Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day Year) Sep 4, 1936 220-32-5701 1 M 2 K Months Days 75 D.C. Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar and once. 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits MD **Prince Georges** Rowie 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12717 North Cliff Road 20720 U.S.A. 11. Marital Status Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married þ ☐ Yes 2 👿 No White If Yes, Give Year or Dates 3 → Widowed 4 □ Divorced 1 ☐ Yes 2 X No Specify. Specify: Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Health Aide 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Health Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ည Horace Fletcher Elenor Cochran 19a. Informant's Name/Relationship (Type, Print) o. Mailing Address (Street and Number or Rural Route Number, City or Town, State 1230 N. Riverside Drive Pompano Beach, FL 33062 Steve Winslow, son 20a. Metrod of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🛛 Burial 2 🗆 Cremation 3 🗆 Removal from State Ft. Lincoln Cemetery Oct 12, 2011 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Lice see 22. Name Slack Puner Far Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one caus, on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ disease or condition resulting in death) Medical **Examiner** Se wentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Physician: The law requires that the death certificate be executed ten the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 attending philor use as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day the detached Unknown been signed by should be detact Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 □ Probably 4 □ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? this certificate has 1 Yes Be (funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes ဂ 2 Inpatient 2 ER/Outpatient 3 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at hin 24 hours after death. the Funeral Director: After 28d. Describe how injury occurred the Hospital or Attending 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation completed filled in by the Suicide 6 Could not be 3 ☐ Suiciae 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practice at: This cause if my showledge, death occurred at the time, date and place, and due to the cause(s) and manner at entact. only one 29b. Signature and title of certifier ျှ 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [] For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 2011 2:50p Patricia L. Anders Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Carrol1 Westminster Dove Hospice House 8. Date of Birth (Month, Day, You Feb. 24, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Year 1947 1 🗆 M 2 🔀 F Months Davs Hours Maryland 64 **Director** 218-50-4611 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location iral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Tes 2 X No Maryland Frederick Rocky Ridge 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral United States 13905 Motters Station Road 21778 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Black, White, etc 1 Never Married 2 K Married <u>ک</u> Maryland 21215-0036 ner than "natural", c t, the Medical Exam 1 Yes 2 No Specify: If Yes Give Specify: White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Moore permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) Business Forms Draftsman Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) မ Margaret L. Hartman Kenneth P. Anders 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1765 Keysville Road, Keymar, Maryland 21757 Margaret Stambaugh / Sister Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Stauffer Crematory Inc.9/27/2011 Frederick, Maryland. 21. Signature of Juneral Service Licer 22. Name and Address of Facility
Stauffer Funeral Homes P. A.
1621 Opossumtown Pike, Frederick, Maryland 21702 Part 1. Enter the disease, or complications that x to ed the death shock, or heart failure. List only one car se on ≱ ch line. . Do not Inter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence or): Examin and burial-tran resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical certificate be P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death both not resulting in the underlying cause give in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 Yes Division of Vital Records, Completed page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy Yes 2 No after death.

Director: After this certificate Yes 2 To the Hospital or Attending Physician, within 24 hours after death.

To the Funeral Director, After this certifics completed filled in by the funeral director, p. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) WPATE 2 LI No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: 5 Pending Natural ☐ Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29d. Date signed (Month, Day, Year) 29b. Signatur 29c. License number ss of person who completed cause of death (Item 23a) (Type, Print) S. Center

State Registrar aistrar's Sianatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 For State Registrar Amend#23a. Prt. 1&IIPerPhys. PCC9—28—1 Certificate of Death 2. Date of Death 3. Time of Death Physician/ Month 09/16/2011 Edith Louise Brooks 5:50 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charles Genesis Elder Care Center La Plata If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year) Hours 1 M 2 F 577-36-4825 Director DC Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Funeral Director La Plata Charles Yes 2 No 10e. Street and Number 23a or 10f. Zip Code 10g. Citizen of What Country? United States 20646 1 Magnolia Drive Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black. White, etc. ģ 1 Never Married 2 Married "natural", or If Yes, Give Year or Dates 1 ☐ Yes 2x☐ No Specify: Specify: Completed 3[™] Widowed 4 □ Divorced Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Housing Management Specialist Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William E. Ayers Lottie Dozier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Diane E. Armstrong/Daughter Box 121387, West Melbourne, Florida 32912 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Arlington Cemetery 11/02/2011 | Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Pope Funeral Homes, P.A. 21. Signature of Funeral Service Licensee M00981 Karlie 5538 Marlboro Pike, Forestville, MD 20746 23a. Part 1. Enter the disease, or complications that caus of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Resimousi disease or condition resulting in death) Medical Due to (or as a consequenc **Examiner** DILLIO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of). Atrial Fibrillation the bunal-tran that initiated events Due to (or as a consequence of) resulting in death) Last physician by Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes No 3 Probably 4 Unknown Be Completed Hypertension, Diabetes Mellitus, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Pneumonia, Cardiovascular Disease autopsy performed? Yes 2 2 No 1 🗌 Yes 25. Was case referred to medical examiner?

1 Yes No 26. Place of Death (Check only one) Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certificate: 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending s after death. 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number filled in by determined City or Town, State) 24 hours a Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year,

SEP 2 8 2011

Baltimore, Maryland 21215-0036

Box 68760

Division of Vital Records, P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Wana Grace Bishop Sept 2011 10:34 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Clinton **Examiner** 4c. County of Death \mathbf{PG} Southern MD Hospital Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** 577-30-5874 1 □ M 2**X** F Months Days Hours 07-27-1923 88 Yrs **Director** Alabama Usual Residence of Decedent 10a. State 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director DC Washington 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3123 Warder St. 20010 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ģ Yes 2 XNo Specify: Black If Yes, Give Year or Dates. 1 Yes 2 X No Specify 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Self-Employed 2 Nurse Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ٩ Fletcher Goodwin Willie Stephens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Amelia Lofton/Daughter 2027 First St. NW Washington DC 20001 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Date 1 \boxtimes Burial 2 \square Cremation 3 \square Removal from State stephen's Cemetery 10-3-2011 Phenix City, AL 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ronald Taylor II FH Signature of Funeral Service Licensee Konald 10583 Middleport Ln. White Plains, MD 20695 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Mygeardal Ph sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ signed by the atte in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Hemo dealing 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy perform death? 2 No Yes 25. Was case referred to medica filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No ၉ 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify)

or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760

and

physician

has

certificate

Certificate:

Medical

27. Manner of Death

Natural

Accident

Suicide

4 - Homicide

29a. Certifier

(Check

29b. Signature and

5 Pending

of gertifier

Investigation 6 Could not be

28a-f shov

Baltimore, Maryland 21215-0036

To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this of

completed

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Avenue SE Sut 310 1328 Southern 31. Date filed (Month, Day, Year RichARD PALMER

28a. Date of injury (Month, Day, Year)

mo

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D0055120

2 🗌 No

28d. Describe how injury occurred

IN/33 him

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Jeptuber 23.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ SEPTEMBER 25 2011 BARNWELL MARY 5:10 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGE'S 7733 MERRICK LANE LANDOVER If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. AUG. 16 084-20-3426 87 Year 924 **Director** Usual Residence of Decedent show or 28a-f shov notified at and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10d. Inside City Limits 10c, City, Town or Location Director 1 X Yes 2 🗆 No PRINCE GEORGE'S MD LANDOVER 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a Funeral 20785 USA 7733 MERRICK LANE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 BLACK 1 Yes 2 No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 X Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+)
2 YRS GOVERNMENT TEACHER ASSISTANT Be 17, Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) မ FLORENCE JONES CHARLES ALLEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 211 NALLEY ROAD LANDOVER, MARYLAND 20785 AUDREY HYMAN/DGT. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State HARMÓNY CÉMETÉRY 9/29/2011 LANDOVER, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 KUID 23a. Part 1. En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock neart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ PULMONARY HYPERTENSION disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner CORONARY ATERY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that in the cause of the c Examiner HYPERLIPIDEMIA the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) ESSENTIAL HYPERTENSION Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2X No Month 5 Other (specify) Day Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2√☐ No 24a, Was an autopsy performed? Yes 2 👿 No has page 2 24 hours after death.

Funeral Director: After this certificate 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 \square Nursing Home 5 X Residence 6 \square Other (Specify) Hospital: 1 X Yes 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 5 Pending 1 XNatural 2 🗌 No M Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🔼 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of 29c. License numbe 29d. Date signed (Month, Day, Year) un D34722 SEPTEMBER 26, 2011 Name and address of person who completed cause of death (Item 23a) (Type, Print) VICKEN POOCHIKIAN M.D. 5632 ANNAPOLIS ROAD #3 BLADENSBURG, MARYLAND 20710 31. Date filed (Month, Day, Year) SEP 2 8 2011 32. Registra Signa State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of M	ai yiaiiu 7		tificate of L				Reg. No	2011	32	811			
	Physicia	an/	Decedent's Name (First, Middle One of the state							Date of De	O.D.	ay Year		e of Death			
Medica Examine			4a. Facility Name (if not institution	, give street and number)	one	020	4b. City, Town, o	r Locatio		9	40	c. County of De		:30PM			
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	e Man r 28a- notifie	Director	Maryland Frederick Mt. Airy 10e. Street and Number 110f Zip Code											Yes 2 X No			
	th with th ms 23a o must be	Funeral	6522 Carrie Lyr		10f. Zip Code 21771							United States					
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Mar 3 🛣 Widowed 4 ☐ Divorced	Never Married 2 Married Armed Forces?				ispanic C in, Mexic Speci	Origin? (Specify can, Puerto Rica ify:	Yes or No- n, etc.)		14. Race - An Black, Wh Specify: W					
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Ma	12 sho lith and 27 is r r traur		19a. informant's Name/Relations Phyllis Garnand			_	Address (Street a							771			
ore,	of Hear of Hear fitem		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation		20b. Place	of Disposi	ition (Name of atory or other place		Date	nt. A		ocation - City					
ţi	t. Page tment tant: I		4 Donation 5 Other (S	(pecify)	1		e Cemete		10-1-2	011	Mt.	. Airy,	Maryl.	and.			
Thy III's Garliand / Daughter O322 Carrie Lynn Court, Mt. Alry, Ma 20a. Method of Disposition O322 Carrie Lynn Court, Mt. Alry, Ma 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location 1 M Burial 2 Cremation 3 Removal from State Cemetery, crematory or other place) Pine Grove Cemetery 10-1-2011 Mt. Ai 21. Signatur, of reral Service (Cemeter) Stauffer Funeral Homes P. A. 1621 Opossumtown Pike, Frederick									cick, M	arvlan	1 21702						
l,	al control i		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between											nate Between			
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Performance of the performance o									ormed? death?								
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Division of	al or At after c Direct d in by									28f. Location (Street and Number or Rural Route Number, City or Town, State)							
_	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certific completed filled in by the funeral director,	ledical	(Check 2 ☐ Medical E	Physician: To the best of caminer: On the basis of examiner.	amination and/	or investia	ation, in my opinio	n. death	occurred at the t	ime, date a	nd place	and due to the	e cause(s) and	manner stated.			
	To the Comp	Σ	only one) 3 X Certifying 29b. Signature and title of certifier	Nurse Practioner: To the	C.A	1/F	29c. License					ate signed (Mon		011			
	10	-	30. Name and address of person v	no completed cause of de	eath (Item 23a)	(Type, Pri	nt)	7/	0065e	cht	RI	OCOL	1 1	OII			
			Carriel	Nheeler	CI	21	P	5,	Kesv	11/2	N	DZ	1784	(
	Stat Registra		31. Date filed (MoSEP, Y27)	2011 32 Registra	r's Signature	Son	aked	•									

death certificate be executed O. Box 68760, نه Records, Vital Physiclan: Division or Hospital or Attending

3altimore, Maryland 21215-0036

Bernerd Straw

Lars Reinhart MD 31. Date filed (Month, Day, Year) State SEP 29 2011 Registrar

29b. Signature and title of certifier

St Mark's Heyoital

I Us

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

P.O. Box 524 Lengthown

10

29c. License number

D0668540

29d. Date signed (Month, Day, Year)

Systember 26, 2011

MO 20650

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 2011 рм Harriell Barker 2:20 Sept. 14 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Montgomery 14635 Bauer Drive #205 Rockville 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Birtripias GA 1 ☐ M 2🏖 F Days Months Hours 1 M27 Par 937 74 Director 272-34-6644 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f sho Examiner must be notified at Director 1 XYes 2 No MD Rockville Montgomery 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20853 14635 Bauer Drive #205 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Was Deced Armed Forces? Yes 2 A No 14. Race - American Indian Black, White, etc. 1 Never Married 2X Married þ 1 Yes 2 If Yes, Give Year or Dates Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Black "natural", 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filled within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainmests. life. DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Private Industry Caregiver Be 17. Father's Name (First, Middle, Last) $\, {
m Ukn} \, ullet \,$ 18. Mother's Name (First, Middle, Maiden Surname) မ Mary Lillie Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
14932 MCKnew Rd
Burtonsville, MD 20866 19a. Informant's Name/Relationship (Type, Print) Dorlisa Overton/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, Chesapeake 1 Burial 2 Cremation 3 Removal from State Beltsville, MD 9/28/2011 4 ☐ Donation 5 ☐ Other (Sperify) 21. Signature of Funeral Service 22. Name and Address of Facility Latney's Funeral Home. cc0278 Georgia Ave. NW Washington, DC 20011 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Chronic Obstructive Pulmonary Disease disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Pulmonary Fibrosis Sequentially list conditions Examine if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Pulmonary Hypertension Due to (or as a consequence of) resulting in death) Last physician s the burial Physician/Medical Hypertension Division of Vital Records, P.O. Box 68760 nding p IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I þ Hyperlipidemia 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b lirector, page 2 s performed? 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2X No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral director. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 5 Pending Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title **Certifier** 29d. Date signed (Month, Day, Year, H 603 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5576 20853 Unit B Norbeck Rd Rockville, MD Cho, MD Yoon 31. Date filed (Month, Day, Year) 29

Registrar

2011

SEP

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 03 2011 10 8:45PM M James Leroy Buckler Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
St. Mary s Co. Examiner 4b. City, Town, or Location of Death Mechanics ville 38463 Sonny Lane Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 X M 2 🗆 F 04/02/1944 67 **Director** Yrs 214-42-5398 Charles County Usual Residence of Decedent or 28a-f show notified at 10a State within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 ី No St. Mary's County MD Mechanicsville 10e. Street and Number ō 10g. Citizen of What Country? ral", or items 23a o Examiner must be Funeral 38463 Sonny Lane U.S. 20659 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: White "natural" Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) r than " Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygier 9th Operator Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Page 1 and 2 should be from to the Ments James Howard Buckler traumatic Kay Carol Sullivan 19a. Informant's Name/Relationship (Type, Print, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 other tra Kevin Buckler / Son P.O. Box 221 Loveville, MD 20656 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department o Important: If any injury or # 5 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Faith Episcopal 10/08/2011 Charlotte Hall, MD Funeral Service Licenses 22. Name and Address of Facility Brinsfield-Echols F.H., P.A. . Signatue 30195 Three Notch Road Charlotte Hall M00817 Part 1. Enter the disease implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician | disease or condition resulting in death) Cardio Respiratory Arrest Medical Due to (or as a consequence of) **Examiner** Metastatic Carcinoma of Colon to Liver if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Li Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death Day 5 Other (specify) the a 9 Unknown 9 Unknown cate has been signed by a page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Ves 2 No After this certificate has 2 X No 1 🗌 Yes 25. Was case referred to medical B 26. Place of Death (Check only one) examiner' 1 🗆 Yes 2 🔀 No Hospital Other: 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify, Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending injury 1 Yes 2 No after death Accident Investigation M the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a

To the Funeral D 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State

29b. Signature and title of certifie

(Check

only one)

24435 Mervell Dean Rd., Hollywood, MD 20636 aistrar's Sianatui

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year) 2

Je1

11-07404

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Sharon Lee Bailey State of Maryland / Department of Health and Mental Hygiene 2011 32815 1- For State Certificate of Death Reg. No. Registrar Decedent's Name (First, Middle Last) 2. Date of Death Physician/ 3. Time of Death Month Day October 3, 2011 **Medical Examiner** 0829 hrs Bailey Sharon 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death St. Mary's St. Mary's Hospital Leonardtown **Funeral** 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Months Days Hours Director 1967 Feb. 28, Country) PA 178-54-0384 44 Yrs. 1 M 2 X F Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 X No 28a-f shov Great Mills St.Mary's hours after death with the Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 百 USA 22070 Clipper Drive 20634 23a Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married White, etc. 1X Yes 2 If Yes, Give Year 3 Widowed 4 X Divorced 1 Yes 2X No specify: White Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after
Department of Health and Mental Hygene.
Important: If item 27 is marked other than "natural",
injury or other fraumatic event, the Medical Examiner. Specify. δ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) 12 Health Care Record Keeper 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) æ Harold Leroy Bailey Sandra S. Cox 19a. Informant's Name/Relationship (Type, Print) ဠ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22070 Clipper Drive, Great Mills, MD 20634 Sandra S. Brown/Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State crematory or other place) 10/08/2011 Alexandria, VA Metropolitan 4 Donation 5 Other Specify 21. Signature of Funeral Service Licer 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. uchaelo 41590 Fenwick Street, Leonardtown, MD 20650 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Multiple drug intoxication involving morphine, Physician Approximate Interval Between Onset and . /Medical a Diazepam, Carisoprodol and Quetiapine Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and Physician/Medical AMENDED 23a, 27, 28a-f, per me, g920 10-1/-11 sm attending physician or use as the burial X UNPENDED Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 ✔ No 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 ✔ Probably 4 Unknown Completed Division of Vital Records, certificate has been ector, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed ✓ Yes 2 No 2 No 1 Yes Hospital or Atteoding Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Be Other Nursing Home 5 Residence 6 Other: this 1 V Yes 2 No After 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Certification Natural 5 Pending 1 Yes 2 X No unknown death. Director: fd 10-3-11 fd 7:38 am 2 Accident 24 hours after d 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 22070 Clipper Dr. 3 6 X Could not be Suicide determined (Specify) found at residence Great Mills,Md. Homicide 29a. Certifief 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Sa within 2 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, 29b, Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. October 4, 2011 and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) State Registra

DHMH 17 Rev 1/2001 **OCME 2006**

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death September 26 2011 Physician/ 11:20 P M Thomas F. Barry Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5926 Milton Avenue Deale Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Sex 1 X M 2 □ F 7. Age (In vrs. last birthday) **Funeral** Days Min. 0972791938 Maine Director 578-50-3910 72 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b, County 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 X No Maryland | Anne Arundel Deale 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 5926 Milton Avenue 20751 death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married þ 1X Yes 2 No If Yes, Give Year or Dates, 1959–65 Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 No Specify: Specify: White "natural", Completed 3 Widowed 4 Divorced of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Telecommunications Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) မ Thomas Francis Barry Alice Lowell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5926 Milton Avenue, Deale, Maryland 20751 Mary Barry/Wife 20b. Place of Disposition (Name of cemetery crematory or other place)
Kalas Crematory 20a, Method of Disposition 20c. Location - City or Town, State 1 \square Burial 2X Cremation 3 \square Removal from State ö Department of Important: If any injury or 09/27/2011 Edgewater, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fune 22. Name and Address of Facility George P. Kalas Funeral Home MD 21037 2973 Solomons Island Road, Edgewater, 23a. Part 1 Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ph, sician/ KARS Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to lor as a consequence of if any leading to knowed cause. Enter Underlying Exami attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the at d be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 No 3 □ Probably 4 □ Unknown 1 🗌 Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate to completed filled in by the funeral director, page 2 🗌 No Yes 2 1 Yes the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No မ 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of Injury at 28d. Describe how injury occurred work? 1 Natural 5 Pending injury 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nursa 29b, Signature and title of certifier 29d. Date signed (Month, Day, Year) 09/27/2011 min D52245

State Registrar

31. Date filed (Month De 2 9 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael Freeman, 116 Defense Highway, Suite 400, Annapolis, Maryland 21401 gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2011 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 4:00 AM LDUGULA Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death **Examiner** Bow Rince Date of Birth (Month, Day, If Under 24 Hrs. 9. Birthplace (State or Foreign last birthday) **Funeral** Hours **Director** 28a-f show 10d. Inside City Limits er than "natural", or items 23a or 28a-f sho , the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20774 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Black Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired). 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) egistered traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ W permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 50 N 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Byral Route Number, City or Town, State, Zip Code) KIDGE LAC 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

ETHEL CEMETTRY 10-4-11 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ALEXANDRIA 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated second). Examine Due to (or as a consequence ci): attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Pregnant at time of death signed by the at d be detached for ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy this certificate 1 Yes 2 No Yes 2 completed filled in by the funeral director, 25. Was case referred to medica Hospital or Attending Physician: 26. Place of Death (Check only one) Be examiner? Hospital 2 No 1 Tyes မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 24 hours after death.

Funeral Director: After injury 1 Natural 5 Pending Accident Investigation 6 Could not be ☐ Suicide 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nyrse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney For State Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) September 29, Physician/ 2011 Genet Arefaine Belay 11:58 p.™ Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Holy Cross Hospital Silver Spring 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 977 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Hours 579-27-5274 **Director** 1 🗆 M 2 🔀 F 34 Yrs September 6, Ethiopia Usual Residence of Deceden 23a or 28a-f show it be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1X Yes 2 No Rockville Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe is 23a or r must b Funeral 20853 within 72 hours after death with United States 12630 Viers Mill Road items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Examiner Black, White, etc 0 1 Never Married 2 Married þ Yes 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Ethiopian If Yes, Give Year or Dates Specify: "natural" 3 Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry
National Institute 15. Decedent's Education (Specify only highest grade completed) than College (1-4 or 5+) Elementary/Secondary (0-12) and Mental Hygiene. of Health the Data Entry Clerk 1 year Be 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental H Important: If Item 27 is marked any nijury or other 17. Father's Name (First, Middle, Last) Samue1 မ Wolde Kiros Arefaine Belay-Assa 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12630 Viers Mill Road; Rockville, Maryland 20853 Bilen Arefaine Belay (Sister) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 M Burial 2 Cremation 3 Removal from State Joseph Cemetery Oct.8,2011 Addis Ababa, Ethiopia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility R. N. Horton Company Morticians, Signature of Juneral Signature Inc.;600 Kennedy Street, N.W.; Washington, D.C. 2001 Doundle 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final -Physician/ Asystolic Cardiac Arrest disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Severe Metabolic Acidosis Seque tially let conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): Acute Respiratory Failure Physician: The law requires that the death certificate be executed sician and burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last physician s the buria Physician/Medical Seizure Disorder Box 68760 IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Fctopic pregnancy for in the past 12 month Month Day Year 5 Other (specify) Pregnant at time of death ed by the a 9 Unknown Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Tes 2 No 3 Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy certificate has Yes 2 X No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Was case referred to medica Be Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) 2 X No 1 Tyes 1 X Inpatient 2 - ER/Outpatient 3 - DOA မ After this funeral 28c. Injury at work?
1 Yes 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certificate: or Attending XNatural 5 Pending 2 \square No after death. Director: A id in by the f Accident Suicide Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined within 24 hours a

To the Funeral C

completely filled To the Hospital Medical X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Holy Cross Hospital; 1500 Forest Glen Road; Silver Spring, Maryland M.D.; Nabila Khan, 32. Registra 's Sign

State Registrar 29b. Signature and title of certifier

29c. License number D65305 29d. Date signed (Month, Day, Year)

September 30, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 9:17 PM M 2011 Sent Medical Maryann Ravenel 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick 111 Council Street Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) Funeral (Month, Day, Year) lay 22, 1944 1 □ M 2 🔀 F Months Davs Hours Georgia 253-76-8295 Director 67 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location Director Frederick 1 X Yes 2 ☐ No MD Frederick 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21701 U.S.A. 111 Council Street 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 2 X Married Completed by hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: "natural", 3 Divorced 4 Divorced White Year or Dates. injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Interior Design 4 Interior Designer marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental 2 Henry Hyslop Bruen, Jr. Nancy Stuart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 111 Council Street, Frederick, Maryland 21701 R. Jerry Coates/ Husband 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 09/27/11 Smithsburg, Maryland 22. Name and Address of Facility
Robert E. Dailey & Son Funeral Homes, P.A.
Frederick, MD 21701 21. Signature of Funeral Service Licent 1201 North Market St., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ACUTE MYELOGENOUS LEVKEMIA Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) that the de th cer ificate be executed and Due to (or as a consequence of) resulting in death) Last physician a Physician/Medical ttending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Year Month Day Pregnant at time of death
Unknown the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy perform 1 ☐ Yes 2 ☐ No this certificate Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred injury 5 Pending

Box 68760 Records, Division of Vital Hospital or Attending Director; After

Certificate: 1 Hatural 2 Accident 1 ☐ Yes 2 ☐ No Investigation completed filled in by the Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide determined City or Town, State) within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 031761 29b. Signature and ess of person who completed cause of death (Item 23a) (Type, Print) SOI W SEVENTH ST. FREDERICK 32 Registrar's Signatur State Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 32820 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ SEPTEMBER 29, RICHARD CALVIN CRATER 6:00 AM Medical 2011 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death CHESTER RIVER MANOR KENT CHESTERTOWN . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign Country NEW JERSEY 8. Date of Birth 1 **X** M 2 □ F Months Days Min. 9~24-1932 057-28-5013 **Director** 79 Usual Residence of Decedent or 28a-f show at filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sl any injury or other traumatic event, the Medical Examiner must be notified. 1 Yes 2 X No MD **KENT** CHESTERTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral | 8700 PARK DRIVE 21620 UNITED STATES Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give 1 Never Married 2 XMarried Black, White, etc. ģ Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: Specify: WHITE Completed 3 Widowed 4 Divorced Year or Dates. 1952-1954 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) TEACHER **EDUCATION** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) LESLIE S. CRATER EDNA MAY CALDER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHIRLEY CRATER/WIFE 8700 PARK DRIVE CHESTERTOWN, MD 21620 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place, 4 Denation 5 Other (Specify) CHESAPEAKE CREMATION 09/29/2011 STEVENSVILLE, MARYLAND 21. Signature of Funeral Service License 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.
130 SPEER ROAD CHESTERTOWN, MARLAND 21620 23a. Pan 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician/ EM STA Onset and Death EW M disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy

Pregnant at time of death 5 Other (specify) 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day been signed by the should be detached g Unknown g
Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by BCHEMIC CARDIONYURATION 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 s autopsy performed? Yes 2 No 1 Yes 2 No ours after death.

leral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 20 No Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural injury 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 7 only one 29b. Sigria ure and title of certifie ٥ 29d. Date signed (Month, Day, Year) D6060301 Name and address of person on who completed cause of death (Item 23a) (17 pe, Print) michael 31. Date filed (Month, Day, Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 23 IDTICA LOSMA Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Kris Leigh Assisted Living Gambrills Anne Arundel Social Security Number **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🗶 F Months Romania Min. Hours May Month, Day 1927 84 **Director** <u>578-76-7932</u> or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland | Prince George's 1 X Yes 2 No Bowie ò 10e. Street and Number 10f. Zip Code iral", or items 23a or Examiner must be 10g. Citizen of What Country? Funeral 3502 Ellen Court 20716 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian þ 1 Never Married 2 Married Black, White, etc. 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo "natural", 3 X Widowed 4 □ Divorced Completed White Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Nurse Health Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, should be file hand Mental F မ Ilie Luca Susana Popa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health an
Important: If item 27 is
any injury or other trau Doina Barbu/ P.O.A. 3502 Ellen Court Bowie, MD 20716 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 💢 Burial 2 🗆 Cremation 3 🗆 Removal from State conetery of charactery of other place)
Church Cemetery 4 Donation 5 Other (Specify) 9/29/2011 Bowie, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home alle And 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to or as a consequence of that the death certificate be executed ng physician and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day signed by the a 1 Yes 2 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform UTI Hospital or Attending Physician: The Division of Vital 25. Was case referred to predical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 X Other (Spec မ 1 Inpatient 2 I ER/Outpatient 3 I DOA funeral 27. Manuer of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1/ Natural work? 1 🗆 Yes 2 🗀 No 5 Pending injury Investigation 6 Could not be Accident 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) þ 28f. Location (Street and Number or Rural Route Number, determined City or Town, State completed filled in within 24 hours a

To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature 29d. Date signed (Month, Day, Year) 9

State Registrar 31. Date filed (Month, Day, Year) SEP 2 9 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 32822 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 29, Physician/ Lorraine Elizabeth Clum September 2011 10:57 Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Caroline Caroline Nursing & Rehab Denton 8. Date of Birth
(Month, Day, Year)
Sept. 14, Social Security Number If Under 1 Year If Under 24 Hrs. Hours Min. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday **Funeral** Days 1 🗆 M 2 🕱 F Months 1925 Washington, DC Director 579-26-0129 86 Usual Residence of Decedent 28a-f shor 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland ıral", or items 23a or 28a-f sho | Examiner must be notified at Director 1 🗌 Yes 2 🔀 No MD Caroline Denton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral be filed within 72 hours after death with 520 Kerr Avenue 21629 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Yes. Give "natural", 3 X Widowed 4 Divorced White Year or Dates the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Prince George's Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Assistant County Government 12 other 1 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Department of Health and Mental Important: If item 27 is marked or any injury or other traumatic eve မ Charles Edward Buete Nellie Elizabeth Moriarity Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeffrey A. Clum / Son 5325 Ox Road, Fairfax, VA 22030 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 10/3/2011 Suitland, Maryland 21. Signature of Fuperal Service Ligensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final COPD Physician disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) 1 Yes 2 L 9 Unknown been signed by the should be detached q Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u></u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s autopsy Yes 2 L 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ည 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Mann Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signa e and title of certifie 29d. Date signed (Month, Day, Year, MD 00023922 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Preston MD 2165 hoftonk Road

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month,

oct 0 3 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ Helen Marie Cole 11:40 2011 September Medical 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Montgomery Takoma Park 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth Funeral Days (Month, Day, Year) February 6, 1 □ M 2 🕱 F 396-14-2716 Wisconsin Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Examiner must be notified at Director 1 X Yes 2 ☐ No Prince George's Hyattsville Maryland o 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral USA 20782 3600 Hamilton Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No If Yes, Give Black White etc. 0 þ 1 X Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 'natural", Completed 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than HUD Elementary/Seconday (0-12) College (1-4 or 5+) Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Page 1 and 2 should be Earl Marion Cole Helen Frances Hebert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a 3600 Hamilton Street, Hyattsville, MD 20782 Paul E. Mihill / Friend 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If it any injury or o once. 1 🖾 Burial 2 🗌 Cremation 3 🗍 Removal from State 10/4/2011 Adelphi, Maryland George Washington Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
4739 Baltimore Avenue
Ach Janning Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do wit enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Atherosclerati disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, issuing to include the cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Que to fores a nonsectionne on To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Dav Year Pregnant at time of death Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 Yes 2 No 3 Probably 4 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been significate of the funeral director, page 2 should to completed filled in by the funeral director, page 2 should the funeral director. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 2 No 1 Tes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 2 🗹 No Certificate: To 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manuer of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a To the Funeral D Medical

DHMH 17 Rev 7/2009

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State

Registrar

29a. Certifier

(Check

29b. Signature and title of certific

31. Date filed (Month. Da

/in/

3 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0/011

7600

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 32824 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 23, 2011 Jesse L. Doody 7:25p Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Kline Hospice House Frederick Mt. Airy Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours Min. 212-54-6813 **Director** 1 **X** M 2 □ F 61 Sept. 3, 1950 Maryland Usual Residence of Deceder or 28a-f show notified at 10c. City, Town or Location within 72 hours after death with the Maryland 10a. State 10b. County 10d. Inside City Limits Director 1 ☐ Yes 2 🗓 No Maryland Frederick New Market 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ıral", or items 23a o Examiner must be Funeral 11812 Darby Road 21774 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Completed 3 Widowed 4 Divorced Specify: White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 Ford Motor Company Service Advisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) s 1 and 2 should be filed of Health and Mental H If item 27 is marked ot r other traumatic ever ၉ permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic e Paul L. Doody Martha Howard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathy Doody / Wife 11812 Darby Road, New Market, Maryland 21774 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Stauffer Crematory Inc.9/27/2011 Frederick, Maryland. Signature of uneral Serve 22. Name and Address of Facility Stauffer Funeral Homes P. A. 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final PANEREATIC CANCINOMA Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of): the attending physician and ched for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen s 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed death? 2 1 No 1 Yes_ 1 Tyes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify 405P/CE Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending work 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \square Homicide

Director: After this certificate filled in by the within 24 hours after To the Funeral Direct

> Cy State

Medical

29a. Certifier (Check

29b. Signature and title

Ronald E.

31. Date filed (Mo

3 □

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD

Miller,

MD

#4_Culwell

32 Registrar's Signatur

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D26499

Drive, Mt. Airy, Maryland 21771

9-26-11

Ceptifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 20b.per fh.g920 10-27-11 sm State of Maryland / Department of Health and Mental Hygiene

32825 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Day Month Year Ruth G. Devins October 23:24 PM /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harford Memorial Hospital Havre de Grace Harford If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) 1 □ M 2 KF Director 93 158-12-8677 July 21. 1918 Jersey New Usual Residence of Decedent filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Event and the restrict alone. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 ☐ Yes 2 ☐ No MD Cecil Perryville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1446 Perryville Road 21903 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐XNo If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 δ 1 ☐ Yes 2 🌠 No Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) James Rigby ဂ္ဂ Catherine Clark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Richard Devins (Son) 295 Sudbury Rd., Point Pleasant, NJ 08742 20b. Place of Disposition (Name of cemejery, crematory, or other place)
Kettle Creek Cemetery
Vabounder Cemetery
Vabounder Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brick. NJ Signature of Funeral Service Licensee 22. Name and Address of Facility Van Hise & Callagan Funeral Home 812 Arnold Ave, Point Pleasant Beach, NJ 08742 23a. Part 1. Enter the disease or complication shock, or heart failure. List only one can ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death use on each line. Immediate Cause (Final disease or condition resulting in death) emona Physician /Medical e to (or as a consequence of): **Examiner** Sequentially list conditions, Examine day leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 You 24a. Was an autopsy performed? Yes 2 No 2 0 1 ☐ Yes To the Hospital or Attending Physician: 'within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Dath 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural ≥ Accident (Month, Day, Year) 1 ☐ Yes 2 🗌 No completely filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical 29a. Certifier Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mikityanskaya M.D.
Antean d 2011 32. Registrar's Signature Inna Union m.D mD 21078 State Descut. Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Co. 1

			1 - State of Maryland / Dep State of Maryland / Dep Registrar Ce	rtificate of Dea			giene {)	32826	
	Physicia		1. Decedent's Name (First, Middle, Last) Marjorie Mae DeSimone			2. Date of Dea		2011	3. Time of Death 9:15 A M	
	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Loca	b. City, Town, or Location of Death			ember 27, 2011 9:15 A M		
-			2601 Enterprise Road	Bowie	Bowie			ce Geo	rge's	
	Funeral	Г	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If U	Under 24 Hrs. ours Min.	8. Date of Birt (Month, Da	:h		place (State or Foreign	
	Director		Usual Residence of Decedent 1 X M 2 F 86 Yrs.			ct. 1,		Virg		
	and show at	٥	10a. State 10b. County 10c. City, Town or L	ocation		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			0d. Inside City Limits	
	Aaryla 8a-f s tiffied	rect	Maryland Prince George's Bowie						1 💢 Yes 2 □ No	
	the N	اقا	10e. Street and Number	10f. Zip Code	-		10g. Citizen	of What Coun	itry?	
	s 23s	Funeral Director	2601 Enterprise Road	20721			USA			
	death r item ner n		11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	Was Decedent of Hispan If Yes, specify Cuban, Me	nic Origin? (Spec lexican, Puerto F	cify Yes or No- Rican, etc.)		Race - Americ Black, White, e		
36	after al", o	d by	1 Never Married 2 Married 1 Yes 2 No If Yes, Give	1 ☐ Yes 2 Ϊ No Sp	pecify:			^{cify:} Whit		
21215-0036	within 72 hours after death with the Maryland giene. et than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at the Medical Examiner must be notified at	Completed	15. Decedent's Education 16a, Dece	dent's Usual Occupation	1			of Business/Inc		
215	in 72 e. nan "r Med	duc	(Specify only highest grade completed) (Give Elementary/Secondary (0-12) College (1-4 or 5+)	kind of work done during OO NOT use retired)	g most of workin	g			,	
	y with ygien her th	Be C	12 Homer	naker			Own H	ome		
and	be filed of the filed of the filed of the filed of the file event,	To B	17. Father's Name (First, Middle, Last)		Mother's Name					
Maryland	should b and Mer is mark raumatio		William Floyd Raynor 19a. Informant's Name/Relationship (Type, Print) 19b. Mail		ate Virg				2-4-1	
	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. At the fleath 21s marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	3	, , , , , , , , , , , , , , , , , , , ,	ing Address (Street and N L Enterprise					(ode)	
ē,	e 1 and 2 t of Health If item 27 or other tr		20a. Method of Disposition 20b. Place of Disp	osition (Name of		ate		on - City or To	wn, State	
<u>=</u>	Page nent o ant: If ury or		1 M Burial 2 □ Cremation 3 □ Removal from State Mary 1 and 1 □ Donation 5 □ Other (Specify)	dat Veterans etery	10/3 /2	2011	Chelt	enham.	MD	
Baltimore,	permit. Page Department Important: It any injury or once.	2	21. Signature of Funeral Service Liver ee	2. Name and Address of	Facility Robe	ert E.	Evans	Funera	1 Home	
		- 1	23a. Part 1. Enter the disease, or complications that caused the death. Do not en	16000 Annapo er the mode of dying, suc				20/15	Approximate	
P	h sician/		shock, or heart failure. List only one cause on each line.	mbost	1.0	roll	COLL	. ()	Interval Between Onset and Death	
	Medical Examiner		disease or condition resulting in death) a. Due to (or as a consequence of):	chesta	two or	Your	CON C	anco	year	
15°		-	Sequentially list conditions, b.							
7	nsit ed	Examiner	if any leading to immediate cause. Enter Underlying Cause (Disease or injury							
	cate be executed physician and sthe burial-transit		that initiated events c. Due to (or as a consequence of):							
760	ysicia	edical	d							
9,789	refullicate be inding physicia use as the bu		IF FEMALE:							
9 X	ttendi	ian/	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3	Ectopic pregnancy				Date of delive	ery Day Year	
Box	s that the death certifies igned by the attending p be detached for use as	Physician/N	1 Ves 2 No 4 Pregnant at time of death 5 9 Unknown	Other (specify)				WORTH	Day	
ords, P.O.	ed by	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in	Part I.	23e. Did to	bacco use c	ontribute to th	e cause of death?	
Š,	n sign	q pe				1 🗆 🕆	res 2 N	o 3 🗆 Prot	oably 4 🗆 Unknown	
Corc	s been sig	ompleted				24a. Was a		b. Were autor	osy findings available	
Kec F	s certificate has b director, page 2 s	mo				autop perfo	rmed?	death?	mpletion of cause of	
	s certifical	BeC	25. Was case referred to medical examiner?	26. Place o	of Death (Check		2 🗀 🔟	1 = 100	2 2 110	
5	his ce	2	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie		☐ Nursing Hom	ne 5 Resid	lence 6 \square (Other (Specify,)	
ָם ה ה	After t	Certificate:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending 28a. Date of injury (Month, Day, Year) 28b. Time of injury	work?		8d. Describe h	ow injury occ	urred		
SIO	death death ctor: /	∰	2 Accident Investigation 3 Suicide 6 Could not be	M 1 Yes		Of Location /S	treat and Nu	mbor or Pural	Poute Number	
DIVISION OF VITAL RECORDS,	S after Direct In Direct I								noute Number,	
Hospit H	within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or invest	tigation, in my opinion, dea	eath occurred at t	he time, date a	nd place, and	due to the cau	use(s) and manner stated.	
tho tho	vithin or the comple		only one) 3 ☐ Certifying Nurse Practitioner: To the best of my knowledge 29b. Signature and title of certifier	, death occurred at the tim 29c. License num				nd manner as s ined (Month, L		
	->=0		1 John	D0040519			9/28/			
Ι,	12	1	30. Name and address of person who completed cause of death (Item 23a) (Type,				-, -0,			
H	-10		Mirza Nusairee, M.D. 1667 Crofton C	<u>enter Suite</u>	1, Cro	fton, N	1D 211	14		
	State Registra	9	31. Date filed (Month, Day, Year) SEP 2 9 2011 32. Registrar's Signature	park						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

		•	For State of Maryland / State of Maryland / Registrar	Certificate of		Reg.	2011 32021		
	Physicia	ın	1. Decedent's Name (First, Middle, Last)		(2)	/ . /	Day Year 2:15 P M		
4	/Medic		Mary M. Dorsey	1	6.7 \	premo	4c. County of Death		
	Examin	er	4a. Facility Name (If not institution, give street and number) FutureCare Chesapeake	4b. City, Town, o	r Location of Death		Anne Arundel		
	Funeral		-	The state of the s			9 Birthnlago (State or Foreign		
	Director		212-05-2401 1□ M 2 🟋 F 95	Yrs. Months Days	Hours Min. Fe	Month, Day, Ye	1916 Maryland		
	pun \star		Usual Residence of Decedent 10a. State 10b. County 10c. City, Tow	vn or Location			10d. Inside City Limits		
	faryla f sho	ō		mold			1 □Yes 2 No		
	28a-	Director	10e. Street and Number	10f. Zip Code		10g.	Citizen of What Country?		
	h with	a Di	644 Southern Hills Drive	210)12		USA		
	death	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of I	lispanic Origin? (Specify an, Mexican, Puerto Rica	Yes or No- n, etc.)	14. Race - American Indian, Black, White, etc.		
030	72 hours after death with the Maryland "natural", or items 23a or 28a-f show cheal Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1 □Yes 2 XNo		. ,	Specify: White		
15-0036	I within 72 ho giene. r than "natur rhe Medical I	Completed	(Specify only highest grade completed)	a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	during most of working	16b	b. Kind of Business/Industry		
717	filed within Hygiene. other than '	mo	Elementary/Secondary (0-12) College (1-4or 5+)	Owner			ry Cleaner		
and	al Hyg othe vent,	Be C	17. Father's Name (First, Middle, Last)		18. Mother's Name (Fir		den Surname)		
<u> </u>	should be and Mental s marked o umatic eve	2	Joseph F. O'Leary		Lilly Wal				
Mar	2 % in E		Total mornial to trainer total or to the control of	b. Mailing Address (Stree 544 Southern			ity or Town, State, Zip Code)		
_	1 and Heal em 2 ther						c. Location - City or Town, State		
Baitimore,	Page nent c ant: If ury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☑ Other (Specify) Entombment	of Disposition (Name of lery, crematory or other pla Lawn Memor: Gardens	ce) 9-30-	11 Ma	rriottsville, MD		
Ball	permit. Pa Departmen Important: any Injury once.		21. Signature of Funoral Service Licenspe			Severr	na Park Funeral Home na Park, MD 21146		
			23a. Part. Enter the disease, or complications that caused the death. Do						
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	T			Onset and Death		
	/Medical		resulting in death) Due to (or as a consequence	e of):					
	Examiner	L	Sequentially list conditions, b.						
	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of rigury that initiated events						
,	execu n and ial-trai	Examiner	that initiated events resulting in death) Last c	e of):					
09/80	ificate be executed g physician and ss the burial-transit	edical	d						
	ertifica ing ph	Med	IF FEMALE:						
X R Q	death certifi e attending ed for use as	ian/	23b. Was decedent pregnant 1 Live birth 2 Fetal dea		су		23d. Date of delivery Month Day Year		
	the de	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 ☐ Other (specify)					
т.	w requires that the de been signed by the should be detached		Part II. Other significant conditions contributing to death but not resulting	in the underlying cause g	ven in Part I.	23e. Did tobac	cco use contribute to the cause of death?		
Kecords,	quires in sigr	d by	Radiation Cystitis			1 ☐ Yes	2 No 3 Probably 4 Unknown		
()	law rei as bee 2 shoi	plete	Radiation Cystitis	0		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of		
ř	The late he	Completed				performe			
VITal	cian: ertific	Be (25. Was case referred to medical examiner?	26. Place of Death (Check only one)					
10	Physic this c	0	1 Yes 2 No Hospital: 1 Inpatient 2 ER/0	Outpatient 3 DOA			ce 6 Other (Specify)		
ב	ding F	ion	1 Natural 5 Pending (Month, Day, Year)	o. Time of 28c. Injury Wo	ork? ☐Yes 2☐No	. Describe now	injury occurred		
VISION	Attend death ctor: y the	ertification: T	3 Suicide 6 Could not be 28e. Place of Injury - At home,			Location (Stre	et and Number or Rural Route Number,		
5	al or safter	erti	4 Homicide building, etc. (Specify)			City or Town,	State)		
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 or	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowled 2 Medical Examiner: On the basis of examination and manner stated.	lge, death occurred at the and/or investigation, in my	time, date and place, and opinion, death occurred	I due to the cau at the time, date	use(s) and manner as stated. e and place, and due to the cause(s)		
	To the within Го the сотры	Me	29b. Signature and title of certifier		se number		d. Date signed (Month, Day, Year)		
	7		money mi	Ds	7531	Je	ptenber 27, 20,1		
	2×		30. Name and address of person who completed cause of death (Item 23a	a) (Type, Print)			**		
	· U		30. Name and address of person who completed cause of death (Item 23a) 31. Date filed (Month, Day, Year) 32. Registrar's Signature SEP 2 9 2011	i muy, S.	ulizoy,	miller	solle, MD 2/108		
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	he he del					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes For State Registra Ameno#'s 23b. 26. Per Phys. PCC10-3-11cr Certificate of Death 3**2828** Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death September Day Physician/ Medical 4a. Facility Name (if not institution, give street and number).

Laurel Regional Hospi 4c. County of Death Prince George's **Examiner** 4b. City, Town, or Location of Death Hospital Laure 9. Birthplace (State or Foreign Country) Wash PC Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Months Min (Month, Day, Year) 578-60-0089 1 🛣 M 2 🗆 F Hours 65 **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director MD P.G. Laurel 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? the Medical Examiner must be Funeral 9865 Muikirk Rd. items 23a 20708 U.S.A. within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. ò þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Black If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify "natural", Specify 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) Giant Food Clerk and Mental Hygie is marked other Be permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked oth any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Balis A. Dunlap Jr. Kayretha Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judy C. Dunlap (Wife) 6003 Goodfellow Dr. Suitland MD. 20746 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Nat"l Cem. 10-3-2011 MD. Laurel MD. ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hunt Funeral 908 Kennedy St. N.W. Wash, 21. Signature of Funeral Service Licer Hunt Francis 3. 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph_sician/ disease or condition ute MYOCOrdial Medical resulting in death) Due to (or consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the carry of Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-tran and Due to (or as a consequence of): nding physiciar Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE for use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) atter in the past 12 months? Day Month Year signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 After this certificate has autopsy performed Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: 1 🗌 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ nesidence 6 ☐ Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 Yes Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 24 hours after death. Funeral Director: A Accident 2 🗌 No Investigation completed filled in by the 6 🗌 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifie Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature 29d. Date signed (Month, Day, Year) D56433 201

DHMH 17 Rev 7/2009

State Registrar Laure 1 Regional huspital

7300 Ugn Duren Rd

Laurel Ms

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registr r's Sign

SEMO)

Christophes

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 20h c per fh g921 11-1-11 vt State of Maryland Department of Health and Mental Hygiene 0 | | 1 - For State Registrar 32829 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 10,096 W Williams Bessie Evans Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Cheverly Prince George's If Under 24 Hrs. Hours Min. **Funeral** . Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 R Months Days 248-84-0997 (Month, Day, Year) 01/06/1941 Year. 70 Country) Director Usual Residence of Decedent 28a-f show 10a. State with the Maryland notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MDPrince George's Bladenburg 1 XYes 2 No ò 10e, Street and Numbe 10f. Zip Code must be 10g. Citizen of What Country? 23a Funeral 5300 Newton Street, #303 20710 items United States Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. an "natural", or iter Medical Examiner 14. Race - American Indian, Armed Forces þ 1 Never Married 2 X Married Black, White, etc 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced Completed Specify: Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ∩e. ∡rthan " c.the IV Elementary/Seconday (0-12) Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the <u>A once.</u> College (1-4 or 5+) 8th Receiving Clerk Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ည Unknown Dorothy Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Dorothy Mae Evans/ Daughter</u> 8555 Hyman Way, #256, Alexandria, VA 22309 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State **Suit Land** Lincoln Mem. Cemetery 1 \blacksquare Burial 2 \square Cremation 3 \square Removal from State $10/\frac{1}{1}/2011$ r, Maryland 4 Donation 5 Other (Specify) Memorial 21. Signature of Funeral Service Licensee M00981 22. Name and Address of Facility Pope Funeral Homes, P.A. harles 5538 Marlboro Pike Forestville, MD 20746 23a. Part 1. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ rena discose Jace Medical Due to (or as a con equence of) **Examiner** auto inmune Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a confinctionne of the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): ing physician a Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: attendi 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death f r use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 🛣 No Month Day Year Pregnant at time of death the Unknown P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Completed 1 Tes 2 X No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner? Hospital: Other: 2 X No <u>ام</u> 1 Inpatient 2 ER/Outpatient 3 DOA this 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours after death.
Funeral Director: After thi leted filled in by the funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 1 Natural 5 Pending injury 2 Accident М Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one)

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year SEP 2 8 2011

Baren

Karen Brook, M.D.

1000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registral's Signa

3001 Hospital Drive, Cheverly MD 20785

59167000

29d. Date signed (Month, Day, Year)

9/24/11

11-07394 Khalid Milak Evans Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2011 32830

		1- For State Registrar	Certifica	ite of Death	IIG WICHTER II		2 U I I	32030
Physic Medical Exam		Oecedent's Name (First, Middle, Last)	EVGAS		-	2. Date of Death	Day Year	3. Time of Death 1850 hrs
		4a. Facility Name (if not institution, give street and Southern Maryland Hosptial Center		4b. City, Town, o	or Location of Death	1	4c. County of Death Prince George	
Funeral Director		5. Social Security Number 6. Sex 217–43–0072 1 1 2 F	7. Age (In yrs. last birth			_	(MM/DD/YYYY) 9. Birt	
Maryland 28a-f show any d at once.	 -	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town o	r Location				10d. Inside City Limits 1 Yes: 2 No
i with the Maryland ms 23a or 28a-f sho be notified at once.	I Director	10e. Street and Number 5203 VIENN	a Drive	10f. Zip Code	5735	100	g. Citizen of What Cour	itry?
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiens and the Maryland with them 23 not 24s fabrout. If them 27 in marked other than "natural", or items 23a or 28s-fabrout. I other tranmatic event, the Medical Examiner must be notified at once	Funeral		Forces?	13. Was Oecedent of H If Yes, specify Cuba 1 Yes 2 N			14. Race - Americ White, etc.	can Indian, Black,
nours aff	ed by	or Dates: 15. Decedent's Education (Specify only highest gr	rade completed) 16a. De	ecedent's Usual Occupuring most of working life	ation (Give kind of v		16b. Kind of Business/Ir	ndustry
11215-0036 Id be filed within 72 hours dental Hygiene. narked other than "natur event, the Medical Exam	Completed	Elementary/Secondary (0-12) College 17. Father's Name (First, Middle, Last)	(1-4 or 5+)	12/	A		N/A	
e, MD 21215-00; I and 2 should be filed with Health and Mental Hygiene item 27 is marked other th r transmatic event, the Mes	To Be C	7	Vaus 19b.	Mailing Address (Stre	Roset	e (First, Middle, Ma	er, City or Town, State,	_ , ,
re, MD 2 is 1 and 2 shou of Health and N if item 27 is n	-	Posetta Lacewel 20a. Method of Disposition	1/mother	5203 V	10NHG	Drid	1/160 MD 20c. Location - City or	20735
		1 Burial 2 Cremation 3 Removal 4 Donation 5 Other Specify: 21 Sign ture of Funeral Service Ticens		y or other place)	K 10	-52011	Riverdo	ite, MD
Balti permit. Departn Import injury		/ Mellelle Wise	nces	75270	d Alexan	idrus Fe	RM RCI, CII	Home 20735 NOWMD
Physician /Medical Examiner			e Disorder	enter the mode of dying	g, such as cardiac o	r respiratory arres	t, shock, or heart	Approximate Interval Between Onset and Death
		or condition resulting in death) Due to (or as Sequentially list conditions,	a consequence of):					
	Examiner	cause. Enter Underlying Cause	a consequence of):					
cuted md transit		d	a consequence of):					
760, cate be exe physician a he burial -	edical		23a,pt.II,27	7,per me,g9	25 3-23-	12 sm		
Box 68760, c death certificate be executed the attending physician and of for use as the burial - transi	Physician/M	23b. Was decedent pregnant in the past 12 months?	outcome of pregnancy birth 2 [gnant at time of death 5	Fetal death 3 Other (Specify)	Ectopic pregna	incy	23d. Date of delivery Month D	ay Year
the		Part ii. Other significant conditions contributing		n the underlying cause	given in Part I.	23e. Did toba	acco use contribute to t	he cause of death?
— % 20 €	ted by	Genetic Disorder(Brok	en Chromosor	ne #15)			2 No 3 Proba	
Rec The licate	Completed					24a. Was an autopsy perform	prior to co	opsy findings available ompletion of cause of
Vital ysician: ysician: his certifi director,	B	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1	Inpatient 2 ✓ ER/Outp		of Oeath (Check of Other, Nursing		esidence 6 Other:	
ion of vending Ph.	ation: To			ne of Injury 28c. Inju	ury at Work? Yes 2 No	28d. Describe ho		
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could not be 4 Homicide (Specify	ce of Injury - At home, farm	n, street, factory, office	building, etc.	28f. Location (Str or Town, Sta	eet and Number or Rur te)	al Route Number, City
Div To the Hospital or within 24 hours afte To the Funeral Dii completely filled in	edical	29a. Certifier (Check only one) 2 Medical Examiner: On the basis and manner	of examination and/or inve	estigation, in my opinion	n, death occurred a	t the time, date an	d place, and due to the	cause(s)
	2	29b. Signature and title of certifier	>m	29c. Licens O.C.			29d. Date signed (Monitor) October 4, 2011	tn, Day, Year)
1		30. Name and address of person who completed cau Russell Alexander MD. Assistant I	use of death (Item 23a) Medical Examiner	900 W. Baltimore	Street, Baltim	ore, MD 2122	23	
St Regist	ate rar	31. Date filed (Month, Day, Year) 32. R	Registrar's Signature			OCME		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Day 2011 October 7 Physician/ 10:20 p M Raymond Howard Fendlay Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Carroll Hospice Dove House Westminster If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number Age (In yrs. last birthday) **Funeral** Months Days Hours octont29ay, Yell937 1 🕱 M 2 🗆 F MD 73 **Director** 213-36-7860 Usual Residence of Decedent 28a-f show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shon any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 XNo Carroll Finksburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 2324 Pin Oak Rd. 21048 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 X Yes 2 No 1955 Š 1 Never Married 2 Married Maryland 21215-0036 1 Yes XX No Specify: If Yes, Give Year or Dates 1959 Specify: White 3 Divorced 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Programmer-Claims/Underwriting Insurance Company 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 0 Nellie Jackson Norman Oscar Fendlay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2324 Pin Oak Rd. Finksburg, MD 21048 Pauline Fendlay - Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Finksburg, Maryland Evergreen Mem. Gardens 10/12/11 4 ☐ Donation 5 ☐ Other (Specify) re of Funeral Service License 22. Name and Address of Facilities Funeral Home & Chapel, PA -K1 412 Washington Rd. Westminster, MD 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner Dut to (or as a nonsequence of) cause. Enter Underlying signed by the attending physician and d be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate has Yes 2 No 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 No Certificate: To 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d Describe how injury occurred 1 Natural injury 5 Pending Accident Investigation within 24 hours after death **To the Funeral Director**: / 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29d. Date signed (Month, Day, Year) 29b. Signatur cause of death (Item 23a) (Type, Print) 30. Name an

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month,

Day,

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra AMEND#23a(a)perMD, 10/7/11; BMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death Physician/ Month 22-2011 Angela A. Fussell 1453 Рм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Holy Cross Hospital Montgomery Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** . Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🛛 F Months 03-18-1954 Country) 577-76-9413 Director GA Usual Residence of Decedent 28a-f show a 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director Examiner must be notified DC No ne 1 X Yes 2 ☐ No Washington 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral Forrester St., 101 20032 U.S. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🖾 No ō 1 Never Married 2 Married Black, White, etc. þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give "natural", 3 Widowed 4 Divorced Black Completed Year or Dates event, the Medical Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+)
Years Clerical DC Government marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ild be file ပ William Stafford Dorothy Fussell or other traumatic and i 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau Frankie Lightfoot/Sister 101 Forrester St., SW / Washington, DC 20032 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 N Removal from State 4 Donation 5 Other (Specify) Mount Olivet Cem. 10-1-2011 Washington, DC 21. Signature of Funeral Service Licenses 22. Name and Address of Facility The House Of Williams Funeral & Crem. Srvc./814 Upshur St,NW/Wash,DC 20011 anu 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line immediate Cause (Final Onset and Death Ph sician/ Acute Asphyxiation with disease or condition Medical resulting in death) Examiner Aspiration of Gastric Contents Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine g physician and as the buriar cansir or Attending Physician: The law requires that the death certificate be executed Upper Gastrointestinal Hemorrhage Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year Pregnant at time of death signed by the a Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Metabolic Encephalopathy 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Multiple Cerebrovascular Accidents 24a. Was an certificate has page performed? Yes 2 No End Stage Kidney Disease 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 💆 No Hospital Other: မ 1 XInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injun 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nerse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b, Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D52503 09-22-2011

Registrar

State

30. Name and address of perso

SEP

31. Date filed (Month, Day,

Shailesh Sheth, M.D.

29 2011

1500 Forest Glen Road; Silver Spring, MD 20910

impleted cause of death (Item 23a) (Type: Print)

Registrar's Signa

Amend Item #5 Cecil County Health Dept State of Maryland / Department of Health and Mental Hygienes 32833 10/06/11**1 - State** rjw Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month C Physician/ P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner to unclwood Year If Under 24 Hrs.
Days Hours Min. Birthplace (State or Foreign Country) If Under Date of Birth 7. Age (In yrs. last birthday) **Funeral** Months Davs 1 🗆 M 2 🗅 Director Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland any injury or other traumatic event, the Medical Examiner must be notified at Director Ceci ElKton 1 X Yes 2 No 10e, Street and Number 10f. Zip Code 10a. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a o Funeral 100 Laure rive 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) tomemakei Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ewis ates on 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 🔏 Burial 2 🗆 Cremation 3 🗔 Removal from State 63 Woodlawn Donation 5 - Other (Specify) 21. Signature of Funeral Service Licen 22. Name and Address 19702 meen Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner RNA Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence on Hospital or Attending Physician: The law equires that the death certificate be executed page 2 should be detached for use as the burial-transit signed by the attending physician and that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2X No 3 Probably 4 Unknown 1 🗀 Yes within 24 hours after death.

To the Funeral Director: After this certificate has keen. 24b. Were autonsy findings available 24a. Was an prior to completion of cause of death? autopsy performed Yes 2 1 🗌 Yes 2 🗌 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No 26. Place of Death (Check only one) completed filled in by the funeral director, Be Hospital မ 1 Inpatient 2 I ER/Outpatient 3 I DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide work? injury 5 Pending 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier ppleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who MMRO 012 31. Date filed (Mon 32. Redistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? for State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Deatl Time of Death Physician/ ma Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. county of Death **Examiner** Citizens Nursing & Rehab. Center Frederick <u>Frederick</u> 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Davs Hours Nov. 23, 1919 Mary land 214-10-1140 91 1 □ M 2X F **Director** Usual Residence of Decede 28a-f show 10d. Inside City Limits at 10a. State 10c, City, Town or Location Director ral", or items 23a or 28a-f s Examiner must be notified 1 ☐ Yes 2X No Frederick Frederick MD 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9030 Bethel Road 21702 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Black, White, etc 1 Never Married 2 Married ş ☐ Yes 2 XNo Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White If Yes, Give Year or Dates "natural", 3

Widowed 4 □ Divorced Completed event, the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Lenora Harley Raymong Keyser permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ijamsville, MD 21754 4530 Prices Distillery Road. Ronald Hartsock (Son) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Brookhill Cemetery 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10/14/2011 Frederick, Maryland 21. Signature of Funeral Service Licensee ney & Basford P.A. Funeral Home E. Church Street, Frederick, MD MO1612 21701 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the m shock, or heart failure. List only one cause in each line. de of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 10 1 Yes 2 months? Month 5 Other (specify) cate has been signed by the a page 2 should be detached? 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Division of Vital Records, Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 1 Yes 2 No this certificate Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2×100 Hospital Other: Certificate: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After injury Matural 5 \square Pending Investigation Accident filled in by the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signalure and title of cer 29d. Date signed (Mo. person who completed ca use of death (Item 23a) (Type, Print) Name and address of Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OCT 11 ^{Day} 2011 JEANETTE SHANNON HYDE 3:10A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death **Examiner** 5630 OWNA LANE LA PLATA CHARLES 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2 🔀 F Months MD . 217-32-2915 3^{Month}0^{Pay}1^Y9ⁿ3 4 77 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD. CHARLES LA PLATA 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 5630 OWNA LANE 20646 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married Yes Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: If Yes, Give Specify:WHITE 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) HYDE'S NURSERY NURSERY OWNER 11th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MIDDLETON LEWIS SHANNON LORENE F. GILROY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LEONARD M. HYDE-SON 5630 OWNA LANE LA PLATA, MD. 20646 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 10-15-11 WALDORF, MD. 21. Signature of Fureral Service Licensee M00479 RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate shock, or heart failure. List only one ca Interval Between Onset and Death Immediate Cause (Final +Tiysician/ disease or condition resulting in death) Medical ato (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): the attending physician and hed for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ Month Pregnant at time of death 1 Yes 27 9 Unknown q | Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has b page 2 sl autopsy performed? Yes 2 X No After this certificate ! 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 D No funeral director, æ 26. Place of Death (Check only one) Hospital: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 🗆 Nursing Home Residence 6 Other (Specify) 28c. Injury at Manner of De 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: work? Natural Accident 5 Pending n 24 hours are. he Funeral Director: Aft 2 🗌 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 2 To the I 29b. Signature and title of certifier 29d. Date signed Month Registrar's Signature State

Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien) State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Loretta Joy Hoopengardner 10:05p M September 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 44457 Three Coves Road St.Mary's Hollywood Social Security Number . Age (In yrs. last birthday) **Funeral** If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🔀 F Months Days Maryland (Month, Day, Nov. 13, Hours **Director** 214-14-7884 88 Yrs. Usual Residence of Decedent or 28a-f show filed within 72 hours after death with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland St.Mary's Hollywood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 44457 Three Coves Road 20636 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes Yes, Give Specify.White 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Education permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Stanley Ashby Addie Adams 19a. Informant's Name/Relationship (Type, Print) Spouse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 44457 Three Coves Road, Hollywood, MD 20636 Joseph Luther Hoopengardner,Jr. 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) 0akland 10/06/2011 Oakland, Maryland Sign Rure of Funeral Service Licens 22. Name and Address of Facility
Mattingley-Gardiner Funeral Home, P.A.
41590 Fenwick Street, Leonardtown, MD 20650 23a. Part (. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Colon cancer Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Cause (Disease or imjury attending physician and I for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 month Month signed by the at d be detached for Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 K No 3 ☐ Probably 4 ☐ Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an cate has to performed certificate 1 Yes 2 No Yes 2 K No director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 4 Nursing Home 5 Residence 6 Other (Specify, filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending injury Accident Investigation
Could not be 1 Yes 2 No 24 hours after deal Funeral Director: Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signate D42597 person who completed cause of death (Item 23a) (Type, Print) 26840 Point Lookovt Rd, Leonardform, us wo 31. Date filed (Month Registrar's Signa State 5 2011 Registrar

DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygien ? For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ HOLCOMBE HANG 2205 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Annapolis 641 Wayward Drive If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign Social Security Number 8 Date of Birth 7. Age (In vrs. last birthday) **Funeral** Hours 1 - M 2 - F California 94 Director 214-46-7180 Jsual Residence of Decedent 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🗓 No Annapolis Marvland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 641 Wayward Drive 21401 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black, White, etc. 2 X No þ 1 Never Married 2 X Married 72 hours after ☐ Yes Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Specify. 3 Widowed 4 Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic. Elementary/Seconday (0-12) College (1-4 or 5+) Home 4 years Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Agnes Wolfinstetter Edward Todd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 641 Wayward Drive, Annapolis, Maryland 21401 Richard M. Holcombe/ Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 9/28/11 Edgewater, MD Kalas Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 ua 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ -MEN disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of, Examir Hospital or Attending Physician: The law requires that the death certificate be executed and -tran that initiated events resulting in death) Last Due to (or as a consequence of) burialattending physician I for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has performed within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 No Yes 2 No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 NO ျ 1 Inpatient 2 I ER/Outpatient 3 I DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 -Natural 5 Pending work? Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1-Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated D 21438 Name and address of person who completed cause of death (Item 23a) (Type, Print)

(ICHAEL J. La FENTA W. FUTDEFENSE HWY ANNAPOLI) MDZIYU) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Month Physician/ October 07, 2011 Judith Jackson 12:104 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Egle Nursing and Rehab Center Lonaconing Allegany 5. Social Security Number 8. Date of Birth (Month, Day, Year) May 25, 1938 9. Birthplace (State or Foreign Country) Virginia If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Funeral 7. Age (In vrs. last birthday) 1 □ M 2 🔀 F Director 577-50-0476 73 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Xes 2 No N/A Washington DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2745 29th Street, NW, Apartment B1 20008 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Pets Pet Sitter 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Raymond Jackson Margaret Heath 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laurie Smith - Daughter 8003 Newdale Road, Bethesda, Maryland, 20814 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date October 08 cemetery, crematory or other place)
Cumberland Crematory 1 Burial 2 Scremation 3 Removal from State Cumberland, Maryland 2011 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A 8 East Main Street Lonaconing, MD 21539 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final CEREBROVASCULARACCIDENT Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, Examiner Due to for an appropriation of the dany, leading to in reeds cause. Enter Underlying Cause (Disease or linjury ending physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year 1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DEMIENTIA 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending within 24 hours after death.

To the Funeral Director. All completed filled in by the fu 1 Yes 2 🗌 No Accident Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Date filed (Month, Day, Year)

OCTUBER 07 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 21, 2011 Physician/ 8:10 A M Carol Diane Jackson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's 7608 Fontaine Bleau Drive # 169 New Carrollton 8. Date of Birth
(Month, Day, Year)
Jan. 3, 1945 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) ocial Security Number **Funeral** 1 □ M 2 🌣 F Days Maryland Months Hours Min. 66 Director Jan. 577-62-2423 Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10d. Inside City Limits 10a, State 10c. City, Town or Location Director New Carrollton 1 X Yes 2 No Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20784 United States 7608 Fontaine Bleau Drive # 169 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black White etc þ 1 Never Married 2 Married **Black** 1 ☐ Yes 2 No Specify: Completed 3 Widowed 4 A Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working if Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) event, the 12th Government Employee Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental E မ Martha Hewlett unk. Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clinton, Maryland Page 1 and 2 5925 Woodland Lane <u> Jackie Jackson –</u> Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State September 1 Burial 2 Cremation 3 Removal from State Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Resurrection 2011 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home, Inc. Sterry 4001 Benning Road NE Washington, DC 20019 -r1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 2 years shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Metastatic Lung Cancer Medical Due to (or as a consequence of): Examiner 14 years Breast Cancer Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Day Pregnant at time of death signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐ Yes 2 ☐ No 2 XN To the Funeral Director: After this certific completed filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 $\stackrel{\mathbf{X}}{\square}$ Residence 6 $\stackrel{\square}{\square}$ Other (Specify) 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work' 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

31. Date filed (Month, Day, Year) State SEP 2 8 2011 Registrar

Cynthia M. Williams, DO 3720 Upton Street NW 32. Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

H0058032

Washington, DC

September 23, 2011

20016

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State MEND#7perFH,9/29/11;BMW,McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 09/23/2011 1:05p M FRANCES VIRGINIA JENKINS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner silver Spring Montgomery Nursing Rehab. Randouph Hills Social Security Number Age (In yrs. last birthday) 73 Yrs. If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 🗆 M 💥 Days Director MĎ 215-36-2552 10/17/37 Usual Residence of Decedent or 28a-f shov notified at 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits with the Maryland Director 1 ¥ Yes 2 □ No Rockville MD Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō ms 23a or must be n Funeral U.S. 20850 903 N. Stonestheet Avenue death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian. "natural", or item edical Examiner n 11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. <u>Ş</u> Never Married 2 Married Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Year or Dates Black Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) leath and Mental Hygiene.
n 27 is marked other than "n Y traumatic event Elementary/Seconday (0-12) College (1-4 or 5+) Blinds 12th Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Henry Jenkins HarrietHoward 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau <u>903 Stonestreet Avenue, Rockville MD</u> 20850 Leona E. Mordica/sister Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place Silver Spring, MD T0/1/ 501T Funeral Servi 22. Name and Address of Facility Snowden Funeral Home Signatu Lice 246 N.Washington St., Rockville, MD 20850 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition septicemia Medical resulting in death) Due to (or as a consequence of) Examiner nfected sacral pressure ulcer quantially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) as the burial-tr sit that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? jo Year Month Dav 5 Other (specify) Pregnant at time of death the 9 Unknown 9 Unknown P.O. by signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by end stage renal disease Division of Vital Records, Hospital or Attending Physician; The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4x Unknown page 2 should 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? Jas autopsy performed? Yes 2 No certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director. Be examiner? Other: 4 Mursing Home 5 Residence 6 Other (Specify) 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of After t Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1X Natural work? 1 Yes 2 No Accident Suicide 24 hours after death Funeral Director: A Investigation pleted filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2.

To the I comple Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 9/23/2011 D52261 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1517 Hugo Circle, Silver Spring, MD 20906 Alan R. Segal. MD. 31. Date filed (Month, Day, Year) State 29 SEP Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month (O Day Year Koser Physician/ Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Allegany Health Rehab. & Nurs. Ctr. Allegany Cumberland 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Jun 14 Country) 1 Q M 2 □ F Director 215-20-5014 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location should be filed within 72 hours after death with the Maryland Director Cumberland MD Allegany 1 XYes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number by Funeral 21502 USA 12216 Bedford Road NE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: "natural", WW II white 3 Divorced 4 Divorced Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) nd Mental Hygiene. marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Tire Company machinist Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Lillian Jane Wagner Charles William Koser permit. Page 1 and 2 should Department of Health and Mi Important: If item 27 is man any injury or other traumati 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, MD 21502 Saide Koser 12216 Bedford Road NE Cumberland wife Baltimore, 20c. Location - City or Town, State 20a Method of Disposition 20b. Place of Disposition (Name of crematory or other place, 2 Cremation 3 Removal from State 10/8/201 Sunset Memorial Park MD Cumberland tion 5 Other (Specify) 22. Name and Address of Facility Scarpelli Funeral Home, PA f Funeral Ser gnature ce Licensee 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset an eath or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part Enter the dis shock, or heart failure. List only one cause on each line Immediate Cause (Final ENDSTAGE Filysicially disease or condition resulting in death) Medical Due to (or as a consequence of) Examine Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 1 🗆 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes 2 death? 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of Certificate: 27. Manner of Death 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) work? 1 Natural 5 \square Pending 1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the 3 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number eted cause of death (Item 23a) (Type, Print) Name and address of person who comp MD. 200 Glenn St. Ste. 302 Cumberland, MD 21502

State Registrar

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 22, 2011 Sahr Masu Kongorkwi 0400 A. M Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Holy Cross Hospital Silver Spring Social Security Numbe 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year) 1945 7. Age (In yrs. last birthday) If Unde 9. Birthplace (State or Foreign **Funeral** Months Days Hours 215-66-7264 Sierra Leone. Director 65 1 **X** M 2 □ F September 30, West Africa Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 X Yes 2 No **Maryland** Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Funeral Sierra Leone, West Africa items 23a 20902 901 Arcola Avenue hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. 14 Bace - American Indian Armed Forces?

1 Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ō 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: Black If Yes Give "natural", 3 Widowed 4 Divorced Completed Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 6 years Law Enforcement Security Guard and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Kongorkwi Sahr Kongor Kumba Lebbie Konomanyi traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s f Health a item 27 i Yei Bona Bayoh (Sister) Trento Court; Gaithersburg, Maryland 20877 other 20a. Method of Disposition permit. Page 1 a Department of H Important; If ite 20b. Place of Disposition (Name of 20c. Location - City or Town, State Oct. 15,201 cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State injury or 4 Donation 5 Other (Specify) Adelphi, Maryland George Washington Cemetery Si ature Funeral Ser 22. Name and Address of Facility R. N. Horton Company Morticians, any servola Inc.:600 Kennedy Street, N.W.; Washington, D.C. 20011 Approximate Interval Between Onset and Death 2 weeks 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph_sician/ Seizure disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Alzheimer's Dementia vears Sequentially list conditions, if any, leading to immediate cause. Enter underlying Examine Due to (or as a consequence of) Cause (Disease or injury burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) nding physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) jo in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Month Pregnant at time of death the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by been signe should be o 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📈 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page performed? Yes 2 X No 1 Yes 2 No or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Z No မ 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28c. Injury at 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending s after death. 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Hospital 24 hours a Medical 29a. Certifier 1 💹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 within 2 To the F 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) paruch Kom M D 0065 485 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Barbara Supanich, M.D.;1500 Forest Glen Road; Silver Spring, Maryland 20910

Registrar

DHMH 17 Rev 06-201

State

SEP 2 8 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical 09/15/2011 Month Chester F. Kinderdine 12:07 P M 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Montgomery Shady Grove Adventist Hospital Rockville . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) 1 M M 2 D F Days Hours **Director** 083-14-9818 12/07/1919 Ohio Usual Residence of Decedent or 28a-f shov notified at death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director FI. Ormond Beach Volusia 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 32174 903 Woodmere Circle 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, "natural", or ite Black, White, etc 1 Never Married 2 Married Completed by 1 № Yes 2 □ No If Yes, Give 1942-1946 Year or Dates.1 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 M No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) General Electric Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve once. Theresa Nagel Frank Kinderdine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 903 Woodmere Circle, Ormond Beach, FL 32174 Gary Kinderine - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Volusia Memorial Park Ormond Beach, FL 4 ☐ Donation 5 ☐ Other (Specify) 09/22/2011 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Danzansky-Goldberg Memorial Chapels 1170 Rockville Pike, Rockville, MD 20852 uluitadi. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death congestive Ph_sician/ disease or condition resulting in death) Medical Due to (or is a consequence of): Examiner piration Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury failure attending physician and for use as the burial-transit law requires that the death certificate be executed rena that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical tension 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cancer 1 Yes 2 No 3 Probably 4 Unknown failure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I page 2 s autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 4 the Hospital or Attending Physician: thin 24 hours after death, the Funeral Director: After this certific mpleted filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: ပ 1 ☐ Yes 2 🖫 No 1 Finpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 10 D 41162 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Germantown, Maryland MD 19529 Doctory Drive Ganti

State Registrar

31. Date filed (Month, Day, Year)

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Division of Vital Records, P.O. Box 68760

62. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JOHN RICHARD KEITHLEY 02:00 AM SEPTEMBER 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 104 WEAVER MEADOWS ROAD CONOWINGO CECIL Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year, Funeral 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign 1 🛛 M 2 □ F MARYLAND NECK Director Yrs. 213**–**28–2007 JÀN Usual Residence of Decedent shov 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director ral", or items 23a or 28a-f s Examiner must be notified 1 Yes 2XXNo MARYLAND CECII CONOWINGO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 104 WEAVER MEADOWS ROAD 21918 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No ARMY If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE 3 Widowed 4 Divorced Specify: "natural" Year or Dates.1945-46 the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. AUTOMOBILE Elementary/Seconday (0-12) College (1-4 or 5+) SEMBLY LINE WORKER MANUFACTURING other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H of Health and Mental of Health and Mental of item 27 is marked ည UNKNOWN EMILY BELL KEITHLEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELAINE ROARK / DAUGHTER WEAVER MEADOWS ROAD, CONOWINGO, MARYLAND 21918 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State NORTHERE ESTATORY OF OTHER CHAR METHODIST CEMETERY OCTOBER 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1, 2011 NORTH EAST, MARYLAND 21. Signal te of uner so vice 22. Name and Address of Facility CROUCH FUNERLA HOME, P.A. 127 SOUTH MAIN STREET, NORTH EAST, MARYLAND21901 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury that initiated events Due to (or as a consequence of): Examin the burial-transit and resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ō Month Year 5 Other (specify) Pregnant at time of death the ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 X Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy performed? Yes 2 No death? 2 🗌 No 1 Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 💆 Other (Specify DAUGHTER 2 X No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Hospital or Attending 1 Natural (Month, Day, Year) 5 \square Pending death. Accident 1 ☐ Yes 2 ☐ No Investigation within 24 hours after death

To the Funeral Director, of completed filled in by the 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) pleted filled in by determined Medical 29a, Certifie 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of ce 29c. License number 29d, Date signed (Month, Day, Year)

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DHMH 17 Rev 7/2009

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

D0062190

2533 AUGUSTINE HERMAN HWY, SUITEA, CHESAPEAKE CITY, MD 21915

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 27, 2011 Anthony Shea Kujawski 1611 hrs Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Cheverly Prince Georges Prince Georges Hospital Center 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Months Days Hours April 9, 1973 454-85-6348 38 Yrs Salem, Oregon **Director** Usual Residence of Decedent 28a-f shov 10b. County 10a. State notified at 10c. City. Town or Location 10d. Inside City Limits Director District of Columbia Washington 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral 240 - 34th Street, S. E.; Apt. 6 20019 United States items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces? Black, White, etc. ö þ 1 X Never Married 2 Married within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates White Specify. "natural" Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) entary/Seconday (0-12) College (1-4 or 5+) the Landscape 12th grade Landscaper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o မ Richard Anthony Raymond Kujawski Jo Beth Rhodes t. Page 1 and 2 should by trment of Health and Mer tant. If item 27 is mark ujury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jo Beth Rhodes Moore (Mother) 9211 Stuart Lane; Clinton, Maryland 20735 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Oct. 1, 2011 cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Department or Important; If any injury or once. ☐ Donation 5 ☐ Other (Specify) Riverdale Park Crematory Riverdale, Maryland Signature of Funeral Serv 22. Name and Address of Facility R. N. Horton Company Morticians, Inc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line nter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final Onset and Death Physician/ Fatal Cardiac Arrhythmia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Hypertensive Cardiovascular Disease Sequentially list conditions, t any tracing to immedicause. Enter Underlying Cause (Disease or iinjury that initiated events Exami Chronic Respiratory Failure -trar Due to (or as a consequence of): resulting in death) Last burialphysician the burial Physician/Medical Morbid Obesity certificate be Box 68760 as attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ō in the past 12 months? Month Year Pregnant at time of death
Unknown 2 No the detached 9 Unknown P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? this certificate 2 X N ☐ Yes Yes or Attending Physician: 25. Was case referred to medica funeral director, Be 26. Place of Death (Check only one) examiner?
1 Yes 2 XNo Other: မ 1 Inpatient 2 X ER/Outpatient 3 I DOA 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Director: After X Natural 5 Pending after death. 1 Yes 2 \square No filled in by the Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State) 4 Homicide determined hours a Hospital 24 hours Funeral Medical 1 Acertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

DHMH 17 Rev 7/2009

Registrar

State

29b. Signature and title of certifie

Date filed (Monti

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Ophnell Cumberbatch,

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.; 3001 Hospital Drive; Cheverly, Maryland 20785

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . Day 2011 Physician/ Sept. 27, Elsie Kent 4:15 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death NATIONAL LUTHERAN HOME ROCKVILLE MONTGOMERY S. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 M 2 F SEPT 14,192 096-18-7698 89 NEW YORK **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location be notified at 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Marylanc Director MD. MONTGOMERY ROCKVILLE Y Yes 2 No 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 9701- VEIRS DRIVE 20850 USA 12. Was Decedent Ever in U.S. . Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2X No Black, White, etc. o þ 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X☐ No Specify: 3 ☐ Widowed 4X Divorced Specify: WHITE "natural" Completed Year or Dates er than "natur the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) SECRETARY US GOVT.-DEFENCE Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, the once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည BJARNE JELLUM ANDERSEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MR. FRANK McGOVERN-EXECUTOR 9701- VEIRS DRIVE, ROCKVILLE, MD. 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State METROPOLITAN CREM. 9/28/2011 4 ☐ Donation 5 ☐ Other (Specify) ALEXANDRIA, VA. 22. Name and Address of Facility
HYSONG CO. 2222-WISCONSIN AVE., NW
WASHINGTON, DC 20007 21. Signature of Funeral Service Lice Will HYSONG CO. 23a. Part 1. Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) ZHEIMERS DEMENTIN Medical Due to (or as a consequence of) Examiner ANDREXIA Sequentially list conditions, if any leadin, to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to or as a consequence of ig physician and as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: asn 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No ξ 1 Yes 2 Month Year Day s been signed by the should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an the Hospital or Attending Physician; The law thin 24 hours after death.

the Funeral Director; After this certificate has page 2 s autopsy performed 🗌 Yes 2 🔀 No 1 Yes the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2 👿 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 V Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred 1 🛮 Natural 5 Pending 2 Accident
3 Suicide 1 Tes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) pleted filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie MULLIN 27 2011 00051158 SEPTEMBER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AN THO MY 9701 VEINI OR PLOCKUILLE nn 20850 11.12 OCT 0 3 2011 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep	oartment of I			211	11 32848		
			Registrar 1. Decedent's Name (First, Middle, Last)	Douth	2. Date of De	Death 3. Time of Death				
	Physicia Medio		Phillip Constantine Laker	nan		Septen	mber 16, 2011 6:20 A. M			
	Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, c	4b. City, Town, or Location of Death			of Death		
لمعبد			5610 - 30th Avenue		sville			nce Georges		
	Funeral Director		5. Social Security Number 6. Sex 1 ★ M 2 □ F 7. Age (In yrs. last birthday 7. Age (In yrs. last) If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		th y, Year) 1948	9. Birthplace (Statem Foreign Country) Jamaica, Indies		
			Usual Residence of Decedent			TOCCODE	1 12,	Jamarea, Indres		
	/land f sho	tor	10a. State 10b. County 10c. City, Town or I					10d. Inside City Limits		
	Mar. 28a-	ire	Maryland Prince Georges Hyatts					1 X Yes 2 □ No		
	ith the 3a or t be r	Funeral Director	10e. Street and Number	10f. Zip Code 207	700		10g. Citizen of W			
	ath w	nue	5610 - 30th Avenue 11. Marital Status 12. Was Decedent Ever in U.S. 13	3. Was Decedent of F		necify Yes or No-		West Indies - American Indian,		
36	ould be filed within 72 hours after death with the Maryland Mental Hygiene. and Med Hygiene. and Metal Hygiene. marked other than "natural", or items 23a or 28a-f show mark ee orbit the Medical Examiner must be notified at	Completed by F	1 ☐ Never Married 2 X Married Armed Forces? 1 ☐ Yes 2 X No 1 ☐ Yes, Give Year or Dates,	If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	an, Mexican, Puer	to Rican, etc.)		k, White, etc. Black		
ŏ	hours natur sical I	lete	15. Decedent's Education 16a. Dec	edent's Usual Occup	pation		16b. Kind of Bu	siness Industry		
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2	d with lygien cher tl nt, the	Be C	9th	Welder				struction		
Baltimore, Maryland 21215-0036	be filed veloutal Hygurked othersic event,	To B	17. Father's Name (First, Middle, Last) George Scott Lakeman		18. Mother's Na		Maiden Surname Chompson)		
ary	2 should be filk th and Mental I 27 is marked c traumatic eve		19a. Informant's Name/Relationship (Type, Print) 19b. Ma	iling Address (Street	and Number or Re	ural Route Numbe	r, City or Town, S	tate, Zip Code)		
Σ			Maureen Eleanor Hayles (Friend) 5610) - 30th A	venue; Hy	attsvill	le,Maryla	and 20782		
ore	- 5 ± 0		20a. Method of Disposition 1 □ Burial 2 Cremation 3 □ Removal from State 20b. Place of Disposition cemetery, cr	position (Name of ematory or other place	ce) Oct.	7°at2011	20c. Location -	City or Town, State		
Ē	t. Page 1 tment of tant: If it ijury or o		4 Donation 5 Other (Specify) Riverdal	e Park Cr	rematory			Le,Maryland		
Bai	permit. Page Department (Important: If any injury or once.						_	ny Morticians,		
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en					Lington, D. C. 20011 Approximate		
l a	nysician/		shock, or heart failure. List only one cause on each line.	,				Interval Between Onset and Death		
	Medical		disease or condition resulting in death) Lung Cancer Due to (or as a consequence of):							
	Examiner	F.	Sequentially list conditions, b.							
	sit sd	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (ursease or impury							
	xecute n and al-tran	Exal	that initiated events resulting in death) Last C							
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3/6	ificate ig phy as the	Med	IS SEMALE.							
× 68	h cert tendin r use	an/I	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1	☐ Ectopic pregnan	icy			e of delivery		
Box	e deat the at hed fo	Physician/Me	1 Yes 2 No 4 Pregnant at time of death 5 9 Unknown	Other (specify)			Mor	nth Day Year		
5	hat the ed by detacl		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause gi	iven in Part I.	23e. Did t	obacco use contr	ibute to the cause of death?		
<u>.</u>	uires t n sign	ed by				1 🗆	Yes 2 □ No	3 X Probably 4 □ Unknown		
Hecords,	w request special spec	Completed				24a. Was		Vere autopsy findings available prior to completion of cause of		
Lec Lec	The la ate ha bage 2	mo;				auto perfo 1 \(\sum \) Yes	rmed?	leath?		
VItal	sian: ertifica ctor, I	Be (25. Was case referred to medical examiner?		lace of Death (Che					
>	Physic this or	욘	1 ☐ Yes 2 🗶 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpati	ient 3 L DOA	Other: 4 \(\text{Nursing Home} \) 5 \(\text{K} \) Residence 6 \(\text{Other} \) Other (Specify)					
on or	nding Fath.: After	Certificate:	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident Investigation 28a. Date of Injury (Month, Day, Year) injury	worl	ryat k?]Yes 2. ☐No	28d. Describe I	now injury occurre	ed		
DIVISION	r Atte ter der rector by th	ertif	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office				r or Rural Route Number,		
5	oital o urs af ral Di		Dulluing, etc. (Specify)							
:	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check conly one) 1	estigation, in my opini-	ion, death occurred	at the time, date a	and place, and due	to the cause(s) and manner stated.		
	Not To t		29b. Signature and title of Certifier	29c. Licens			29d. Date signed (Month, Day, Year)			
			OO Named of the state of the st	Duint)	7010	4	Septembe	er 22 , 2011		
R	2		30. Name and aderess of person who completed cause of death (Item 23a) (Type. IVan Zama, M.D.; 9200 Basil Court;	Suite 200	; Largo,	Mary1ar	d 2077	4		
	Stat Registra	_	31. Date filed (Month, Day, Year) SEP 2 8 2011 SEP 2 8 2011 SEP 2 8 2011	/						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 20

			State Registrar			Certif	ficate of	Death		Re	g. No.			
П	Physicia	n/	1. Decedent's Name (First, Midd			Date of Death Month	Month Day Year							
	Medic		STANFORD HERBERT LEWIS				SEPT					2011	11:33 P ^M	
	Examin						4b. City, Town, or Location of Death CHESTERTOWN					4c. County of Death KENT		
· march			CHESTERTOWN N 5. Social Security Number		SHAB le (In yrs. last b	oirthday)	f Under 1 Year		24 Hrs.	8. Date of Birth	KEN		lace (State or Foreign	
	Funeral Director		543-32-1428	81							30 CounTREGON			
	nd how at	_	Usual Residence of Decedent 10a. State 10b. Count	ty	10c. City, To	wn or Locati	ion					10	0d. Inside City Limits	
	arylar a-f sl fried	Director	MD VEN	T	ROCK	HALL						1 X Yes 2 □ No		
	or 28 or 28 e not	اخًا	MD KENT ROCK HALL 10e. Street and Number 10f. Zip Code 10g. C							g. Citizen of	Citizen of What Country?			
	with t	eral	P.O. BOX 535				21661				UNIT	ED ST	ATES	
	leath items er m	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.		s Decedent of I					ce - America		
36	after c ", or i	þ	1 Never Married 2 XM	larried 1X Yes 2		1 -	Yes 2 XN			110011, 4101,	Specif			
8	ours a stural	etec	3 Widowed 4 Divorce	ed Year or Dates. dent's Education			t's Usual Occu	nation				MITT		
21215-0036	within 72 hours after death with the Maryland giene. et than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at the Medical Examiner must be notified at	Completed	(Specify only hig	hest grade completed)		(Give kind	d of work done NOT use retired	during most	t of worki	ng	6b. Kind of B	ousiness inc	lustry	
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	filed tal Hyg d oth event	Be c	17. Father's Name (First, Middle	e, Last)				1		e (First, Middle, Ma	aiden Surnan	ie)		
ylaı	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	욘	SAMUEL H. LEW	TIS				GRA	CE M	OORE				
Maryland	should be and Ment is marked raumatic e		19a. Informant's Name/Relation	nship (Type, Print)						l Route Number, (State, Zip C	(ode)	
	and 2 Health tem 27		PATRICIA LEWIS 20a. Method of Disposition	S/WIFE		P.O.		ROCK		L, MD 21	Oc. Location	- City or To	wn State	
Baltimore,	age 1 int of t: If it		1 🔀 Burial 2 🗆 Crematio	on 3 Removal from State	, ceme	tery, cremate	ory or other pla				ROCK H	•		
Ē	permit. Page 1 Department of Important: If it any injury or o		4 ☐ Donation 5 ☐ Other 21. Sign Ture of Funeral Service	, , , ,	WEST	00.11		of Facilit						
Ba	Depar Impor any ir		Morenica	MINVelle	NE.	FEL	LOWS, I	ELFEN	BEIN	& NEWNA	M FUNE MD 216	RAL H	OME P.A.	
			23a. Pait 1. Enter the disease,	or complications that cause st only one cause on each lin	d the dea h. Do	o not enter the	he mode of dy	ing, such as	cardiac o	r respiratory arres	t,		Approximate Interval Between	
- P	hysician/		Immediate Cause (Final disease or condition	st only one cause on each in	A	1500	\mathcal{A}	PNE	en n	non i a			Onset and Death	
Medica			resulting in death)	a. Due to (or as	a consequenc	ce of):								
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	and and I-trans	Sequentially list conditions, lf any, leading to immediate cause. Enter Underlying Cause (Disease or impory that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):								-				
	cate be executed physician and the burial-transit		3											
68760	icate j phys is the	Medical		G										
89	certii anding use a		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 Live Birth	of pregnancy	eath 3 🗆 F	Ectopic pregnar	ncv			23d. D	ate of delive	ery	
Box	death ne atte ed for	Physician	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant			Other (specify)				Month Day Yea			
P.O.	requires that the death certific been signed by the attending p should be detached for use as		9 Unknown Part II. Other significant condi		but not resultin	na in the und	erlying cause o	niven in Part	.1	23e Did tob	acco lise cor	atribute to th	ne cause of death?	
σ.	es tha	l by	Fait II. Other significant condi	nions contributing to death	out not resultin	ig in the una	criying oddsc s	giverimirait					pably 4 Vunknown	
Sp.	requir	Completed	-							24a. Was an			psy findings available	
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<u> </u>	n: Th ificate or, par	ပ္တို	25. Was case referred medical	ai			26	Place of De	th (Check	1 Yes 2	LNNo	1 Yes	2 Lano	
Vita	ysicia s cert direct	To Be	examiner? 1 Yes 2 No	Hospital:	ient 2 🗆 ER/	/Outpatient	_ Ot	her:	,	me 5 🗆 Reside	nce 6 🗆 Ot	her (Specify	·)	
of	ig Phy ter thi		27. Manyer of Death	28a. Date of inj	ury 28t	b. Time of injury	28c. Inju			28d. Describe hov				
on	endin eath. or: Afi he fui	fica	1 Natural 5 Pend 2 Accident Inves 3 Suicide 6 Cou	stigation	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,,		Yes 2	No					
Division of Vital Records,	or Att	Certificate:	4 Homicide deter	jury - At home, tc. <i>(Specify)</i>	, farm, street	t, factory, office	9			tion (Street and Number or Rural Route Number, or Town, State)				
	pital ours a eral E filled		29a, Certifier 1 Certifyi	ing Physician: To the best o	f my knowledg	ne death occ	cured at the tim	ne date and	place an	d due to the caus	e(s) and man	ner as state	ed.	
	e Hos 124 h e Fun leted	Medical	(Check 2 Medica	LExaminer: On the basis of	examination and	id/or investiga	ation, in my opir	nion, death o	occurred at	the time, date and	d place, and d	ue to the ca	use(s) and manner stated.	
								d. Date sign						
	12		D0036054 9/262011											
		-	30 Name and address of person who completed cause of death (Item 23a) (Type, Print)								11 0			
	+		Haterac J. S 31. Date filed (Month, Day, Year,	hanahan	JO ID	Spe	4 RD	Bldg!	150	restert	town	M.) c	4620	
	Stat Registra		STP.	2 9 201 32. Regin	rar's Signature	B. A	bartes	•						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 29, Physician/ 2^{Year}_{011} 1:45 a.M. Lepper Carolyn Stone Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's St. Mary's Nursing Center Leonardtown If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Yea 06/28/192 Country)
New Hampshire 1 M 2 XF Director 215-70-9529 89 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State -10c. City, Town or Location Director 1 Yes 2 X No Maryland St. Mary's Hollywood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 43172 Joy Lane 20636 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc "natural", or 1 Never Married 2 Married 2 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify 3 ₹ Widowed 4 □ Divorced Specify: Completed White Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Mus<u>ic Teacher</u> Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ernest C. Stone Marian Hewitt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21762 North Essex Drive, Lexington Park, MD 20653 Amanda Ramey/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State St. Mary's City, MD 4 Donation 5 Other (Specify) Trinity Episcopal Cem 10/04/2011 Brinsfield Funeral Home, P.A. 20650 Signature Moneral Service Consee 22. Name and Address of Facility 22955 Hollywood Road, Leonardtown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Dear Immediate Cause (Final Physician/ disease or condition resulting in death) Medical ue to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and that initiated events Due to (or as a consequence of) resulting in death) Last physician the burial Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) g Unknown g Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed? death? DYSPHAGIA 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 2 ሺ No Hospital: 1 🗌 Yes ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 🔏 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

State Registrar John L.

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bennett

23263

32. Registrar's Signature

00019052

20619

By the Mill Road, California, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens State
 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Nelson Case Marsh October 2011 5:40 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 120 East Patrick Street Frederick Frederick If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 352-24-7839 Director 1 X M 2 □ F Nov. 16, 1924 Illinois 86 28a-f shov 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City. Town or Location 10d. Inside City Limits at Director th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sl traumatic event, the Medical Examiner must be notified i 1 X Yes 2 ☐ No Marvland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21701 United States 120 East Patrick Street 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces?

1 X Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 X Married ð Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Manager Energy Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) ည Everette Earl Marsh Edna Case 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health al Important: If item 27 is any injury or other trau once. 120 East Patrick Street, Frederick, MD 21701 Dorothy C. Marsh / Wife 20a. Method of Disposition
1 □ Burial 2 🛣 Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State October 6, Smithsburg Crematory 4 Donation 5 Other (Specify) 2011 |Smithsburg, Maryland 21. Signatur of Funeral Service Licens Reeney and Bastord PA Funeral Home MO1473 106 E. Church Street, Frederick, MD 21701 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause on each line. 23a. Part 1. Enter the disease, o shock, or heart failure. List Interval Between Onset and Death Immediate Cause (Final としていいいくこして Ph_sician/ accident disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate
Find dying
Cause (Disease or injury Due to (or as a consequence of) g physician and as the burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE detached for use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year 1 | Yes 2 | 9 | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by entia. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Canur 24a Was an performe 2 No Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 ☐ Yes 2 X No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5. Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 24 hours after death. Funeral Director: After 1 Natural 5 Pending 1 Yes 2 No 2 Accident Investigation Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar DHMH 17 Rev 06-2011 29b. Signature and title of certifier

31. Date filed (Month, Day,

witin

Austin Pearre,

201 M

32 Registra s Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

009689

300 West Ninth Street, Frederick, Maryland 21701

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) September 21, 2011 Physician/ 6:25 P M Gale E. Morningstar Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Frederick Citizens Rehabilitation Center Frederick Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min Months Hours **Director** 1 🔀 M 2 🗆 F 90 289-18-5912 June 15, 1921 Ohio Usual Residence of Deced 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location aţ Director notified 1 Yes 2 No Frederick Marvland Frederick 10g. Citizen of What Country? 10f. Zip Code ò 10e, Street and Number must be Funeral with 1 23a United States 21702 2100-B Whittier Dr. #308 items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian er than "natural", or iter the Medical Examiner Armed Forces?

1 X Yes 2 No Black, White, etc. 1 Never Married 2 X Married 1 X Yes þ Maryland 21215-0036 1 Yes 2 X No Specify: Specify: WWII White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Dentistry Dental Technoligist Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Salome Ramseyer permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic c Emery Morningstar other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 409 Magnolia Ave., Frederick, MD 21701 19a. Informant's Name/Relationship (Type, Print) Warren Morningstar / Son Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) SEPT. 23,2011Frederick, Maryland 4 Donation 5 Other (Specify) Stauffer Crematory 21. Signate of Funeral Service Licen Stauffer Funeral Home 22. Name and Address of Facility 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause are each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ emen disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions Examiner cause. Enter Underlying attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 3 Probably 4 Unknown Division of Vital Records, 1 Yes 2 No Completed been sig 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to me 26. Place of Death (Check only one) Be Other: 1 Yes ျာ 1 Inpatient 2 ER/Outpatient 3 DOA rsing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Mann Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred I **Director.** After the din by the funers Natural 5 Pending 1 Yes 2 \square No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours after

To the Funeral Directory tilled in by City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as a stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one) 29d. Date signed (Month, Day, Year) 29b. Signa re-and title of certifier 29c. License number Cax 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Mont)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 1 - State per FDirector, 09/30/11, TM Reg. No. Amend # 18 Kent Co. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 76 Month Physician/ Year PM 01 ERESA 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner QUEEN no Anne MOSPILE OF ANNE a wente If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth **Funeral** 6. Sex 7. Age (In vrs. last birthday) 1 🗆 M 2 🔀 Months Days Hours Min 02/01/1975 MARYLAND **Director** 218-17-6778 36 Usual Residence of Decedent at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director iral", or items 23a or 28a-f s Examiner must be notified 1 Yes 2X No MD OUEEN ANNE'S CHESTERTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral UNITED STATES 218 BURCHARD SAWMILL ROAD 21620 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married 2 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: "natural", Specify: Completed 3 Widowed 4 Divorced WHITE Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) i Health and Mental Hygiene. 12 FOOD SERVICE / WAITRESS event, th Be 18. Mother's Name (First, Middle, Maiden Surname) we1che 17. Father's Name (First, Middle, Last) မ LARRY ELSWORTH LEONARD VIRGINIA KAY WAYKE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 208 EAST MAIN STREET SUDLERSVILLE, MARYLAND 21668 LARRY LEONARD / FATHER 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State = 5 Important: I any injury o 4 ☐ Donation 5 ☐ Other (Specify) 10/03/2011 CHESTER CEMETERY CHESTERTOWN, MARYLAND 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.
370 W. CYPRESS ST. MILLINGTON, MARYLAND 21651 Signature of Funeral Service Lice 23a. Part 1. Enter the disease, or complications that caused the death. o not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ MeH GMic disease or condition resulting in death) 11745 yen Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and anding physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 attending place as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death 5 Other (specify) g Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has t lirector, page 2 s autopsy death? Yes 2 No 1 Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \bowtie Other (Specify) Hospital: ပ 1 🗌 Yes 2 **X**No 1 Inpatient 2 ER/Outpatient 3 DOA HOSPICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 Yes 2 No Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident Investigation filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TEFFREY 21617 FM 31. Date filed (Month, Da Registr State

Registrar

68760 Box (P.O. Records, Division of Vital Hospital or Attending Physician: 24 hours a completed

Baltimore, Maryland 21215-0036

Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD# 11241 SEPTEMBER 26, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GERALDINE SCHECHTER, M.D., VAMC, 50 IRVING STREET NW, WASHINGTON, DC 20422/688 31. Date filed (Month, Day, Year) State 2011 29 Registrar DHMH 17 Rev 7/2009 **ORIGINAL**

State of Maryland / Department of Health and Mental Hygiene) for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last), 2. Date of Death 3. Time of Death Physician/ Cynthia Darleen Meredith SEPTEMBER 9:55 PM 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Doctors Community Hospital Lanheine Prince Georges If Under 1 Year | If Under 24 Hrs. Social Security Number Age (In yrs. last birthday) g. Birthplace (State or Foreign **Funeral** 8. Date of Birth (Month, Day, Year 579-64-383 1 M 2 W 62 -1948 Washington DC Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a, State 10b County 10c. City, Town or Location 10d. Inside City Limits Director MD Prince Georges Hyatsville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1800 Lungitura 1)rive 20782 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. 0 þ 1 Never Married 2 Married Yes 2 110 filed within 72 hours after 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give "natural" Completed 3 Widowed 4 Divorced Black Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within the and Mental Hygiene.
77 is marked others marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Office Administration 12 Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 George Hawkins Gregory Dorothi Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health stem 27 i Michelle Meredith/Daughter 1800 Longford Drive HVaHSVIlle, MD 20782 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ō cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Important: It any injury or 9-30-2011 BeltsVILL, MI) 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Gernaturi 22. Name and Address of Facility Signature of Funeral Service Licensee Rainey's Funcial Home ar KichmondivA 23231 Williamsburg Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final espirato Onset and Death - Ph. sician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Due to or as a consequence of Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Month Year Pregnant at time of death 1 Li Yes 2. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy death? nerformed' 1 Yes 2 🗌 No Yes 2 Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certificeted filled in by the funeral director, . Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 2 400 မ 1 Yes 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Minuer of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Accident Investigation 1 Yes 2 No Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined To the Hospital or within 24 hours a To the Funeral D Medical 29a. Certifier Lectifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Signature and title of certifier MDD 606 11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8118 GOOD LOCK ROAD State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, for State Registrar 32856 Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death Physician/ 2011 Sept. Christine Minnie King Priebe 8:46 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Carroll Dove Hospice House Westminster Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours (Month, Day, Year) 215-44-5235 84 **Director** 1 🗌 M 2 🔀 F June 19, 1927 Usual Residence of Decedent Virginia 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland notified at Director 28a-f 1 X Yes 2 No Maryland Carroll Mt. Airy 10e. Street and Number ms 23a or must be r 10f. Zip Code 10g. Citizen of What Country? Funeral 806 Roller Coaster Court 21771 United States items Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ian "natural", or ite Medical Examiner Armed Forces?
1 ☐ Yes 2 🔀 No. Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: White Specify Completed 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4 or 5+) the Own Home Homemaker of Health and Mental Hygi item 27 is marked othe other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Thomas M. King Mary M. Moses 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Sandra P. Day / Daughter 201 Flower Court Mt. Airy, Maryland 21771 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State September 4 ☐ Donation 5 ☐ Other (Specify) Patuxent Cemetery 27, 2011 Sunshine, Maryland uneral Service Licensee ature of 22. Name and Address of Facility Stauffer Funeral Homes, P.A. Mt. Airy, Maryland 21771 E. Ridgeville Blvd. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Ph sician/ disease or condition weel Medical resulting in death) Examiner over arteral Belienie Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin burial-transi Cause (Disease or injury that initiated events BAINER Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical law requires that the death certificate be Qurun Box 68760 as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) signed by the atte in the past 12 months?
1 ☐ Yes 2 ☒ No Month Day Year Pregnant at time of death Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performe ate 2 🗌 No Yes I or Attending Physician: after death. Director, After this certific 25. Was case eferred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 K Other (Specify) Hospice funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 □ Yes 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending 2 🗌 No within 24 hours after death

To the Funeral Director; A

completely filled in by the Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practitio dge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of ce

State Registrar

5

30. Name and address of p

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 32857 State of Maryland / Department of Health and Mental Hygiene? State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2011 4:30 a. Lawrence Quade, Jr. George September Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner St. Mary's Bushwood 22435 Bushwood Road If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** 1 X M 2 □ F Days Hours (Month, Day, Year) 05/21/1936 Months Director 214-36-4230 75 Maryland Usual Residence of Decedent 3a or 28a-f show t be notified at 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland Direct 1 Yes 2 No Maryland St.Mary's Bushwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral USA 20618 Examiner must 22435 Bushwood Road "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? **Army** 1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. à 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify.White 3 Widowed 4 Divorced Completed Year or Dates traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 1 and 2 should be filed within 72 if Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Merchant Retail 4 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Alice Margaret Morgan George Lawrence Quade, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 22435 Bushwood Road, Bushwood, Maryland 20618 Margaret Diane Quade/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State 10/04/2011 Sacred Heart Bushwood, Maryland 4 Donation 5 Other (Specify) 21. Signoure of Funeral Service Lice 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. 41590 Fenwick Street, Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each Opset and Death Immediate Cause (Final disease or condition Mhole Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or linjury that initiated events physician and the burial-trans Due to (or as a consequence of) resulting in death) Last Physician/Medical that the death certificate be attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Day 2 No ed by the a 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t 23e. Did tobacco use contribute to the cause of death? signed I þ 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has been si rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 Yes 2 No Hospital or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: ER/Outpatient 3 DOA 4 Nursing Home 5 K Residence 6 Other (Specify) ပ 1 Inpatient 2 I within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 1 Natural 5 Pending work 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29d. Date signed (Month, Day, Year) of person who completed cause of death (Item 23a) (Type, Print) 30. Name and add POINT LADKOUT 25500 TMIR 31. Date filed (Month, Day, Year) State OCT Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 🗸 U 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 23, Physician/ 2011 2:15 PM THERESA Υ. ROBERTS Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number, Examiner MONTGOMERY SILVER SPRING CROSS HOSPITAL If Under 24 Hrs. If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 - M 2 - F Days Hours Min. (Month, Day, Year DC 578-38-1700 Yrs Director 08/16/1931 80 Usual Residence of Decedent or 28a-f shov 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location notified at Director 1 X Yes 2 □ No MONTGOMERY SILVER SPRING MD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 27 is marked other than "natural", or items 23a o traumatic event, the Medical Examiner must be Funeral UNITED STATES Page 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Items 23a 20906 14508 HOMECREST ROAD, #514 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Armed Forces?
1 ☐ Yes 2 X No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: BLACK 3 Widowed 4 X Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than College (1-4 or 5+) Elementary/Seconday (0-12) DC GOVERNMENT INSPECTOR 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ PAULINE WATKINS JOHN P. YOUNG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SCOTT A. ROBERTS/SON 1338 NORTH CAPITOL STREET, NW, WASHINGTON DC 20002 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
RIVERDALE PARK
CREMATORY Department of Important: If it any injury or o ☐ Burial 2 X Cremation 3 ☐ Removal from State 09/27/2011 RIVERDALE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility POPE FUNERAL HOMES, P.A. permit. 21. Signature of Funeral Service Licensee M00981 5538 MARLBORO PIKE, FORESTVILLE, MD 20746 23a. Part 1. Enter the disease, or complications that caused the dath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ ACUTE RESPIRATORY FAILURE disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** HYPOXEMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner ADVANCED METASTATIC LIVER CANCER burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physiciar Physician/Medical that the death certificate be 68760 as the l IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant Box (3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year 1 ☐ Yes 2X No 9 ☐ Unknown ed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed? Yes 2 No 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital Other: 2 **X** No 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes မ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death . Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 Yes 2 No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 24, 2011 September 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NABILA KHAN 1500 FOREST GLEN, SILVER SPRING, MD 20910

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 23, Physician/ Ricci Lena 2011 2:40 p M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Country Meadows Retirement Center Frederick Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** 578-05-7976 Davs 96 **Director** 1 M 2XXF Aug 22, 1915 Washington, D.C 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at rector Frederick Frederick Maryland 1 Yes 2 No ᅙ 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA Funeral 21701 5957 Quinn Orchard Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married þ 25E3FNc Baltimore, Maryland 21215-0036 white If Yes, Give Year or Dates 1 Yes 2XX No Specify: Specify 3x Widowed 4 □ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) Own home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Edith Lowry Robert Marshall 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code). 12 Park Avenue, Harpers Ferry, West Virginia 25425 mit. Page 1 and 2 sh partment of Health a portant: If item 27 is y injury or other trau Patricia Pierce - Daughter 20b. Place of Disposition (Name of Date cemetery, crematory or other place)

Gate of Heaven Cemetery

One Date

9-27-2011 Page 1 1 X Burial 2 Cremation 3 Removal from State Department Important: If any injury or Silver Spring, Maryland Ponation 5 Other (Specify) Sin ature of Funeral paylice Licenses 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Anemie Medical resulting in death) Due to (or as a consequence of) **Examiner** blepo Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) ending physician are use as the burial-t Physician/Medical death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten for u Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Pregnant at time of death the g Unknown signed by a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 🗌 Yes 2 No 3 - Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an has page 2 s autopsy certificate Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☑ Other (Specify) Center 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funer injury 1 Natural 5 Pending 2 🗀 No ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Z Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) and title of certifier 29b. Signar 29c. License number 29d. Date signed (Month, Day, Year) 9-23-1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

D

State

2 65 Registrar's Signature Thornows

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 22, 2011 8:10 A M Marian Jean Roth Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Frederick Frederick Record Street Home If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Oct 3, Days Hours 89 174-16-8280 Director 1 🗆 M 2 🔀 F Pennsylvania Usual Residence of Decedent it of Health and Mental Hygiene.

If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director Frederick Frederick Maryland tx Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21701 115 Record Street filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 XXIo Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) U.S. Government Secretary Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked only any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Mabel Eleanor Harris ပ Charles Edgar Brown 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 3403 Rannock Moor, Williamsburg, Virginia 23188 19a. Informant's Name/Relationship (Type, Print) Susan Smyers - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 K Cremation 3 Removal from State 9-28-2011 Frederick, Maryland Stauffer Crematory 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Stauffer Funeral Home 21702 1621 Opossumtown Pike, Frederick, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition Ph sician/ Medical resulting in death) Dw to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner use to (or as a consequence or): eral Director: After this cartificate has been signed by the attending physician and filled in cy the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical or ttending Physician: The law requires that the death certificate be IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown Year Month Dav Part II. Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably W Unknown of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No after death.

Director: After this cartificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 X No Hospital Other: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify, Certificate: 27. Manyler of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Division M 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours a

To the Funeral C

completely filled Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check ertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title ss of person who completed cause of death (Item 23a) (Type, Print) MO vag 31. Date filed (Month, Day, egiştrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | | | Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death September 27, 2011 Physician/ 4:50 P Brenda Joyce Reyes Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Casey House Rockville 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 1 🗆 M 2 🗶 F January 18. 1941 Lenore. Director 231-52-2752 70 Usual Residence of Decedent show 10d. Inside City Limits 10b. County 10c. City, Town or Location 72 hours after death with the Maryland Director ms 23a or 28a-f s must be notified 1 🗌 Yes 2 🗶 No North Potomac Maryland Montgomery 10g. Citizen of What Country? 10e, Street and Number Funeral 20878 **United States** 14520 Antigone Drive "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by 2 X No 1 Yes If Yes, Give Specify: Caucasian Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 X Divorced Year or Dates er than "natur ; the Medical E 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Police Department Police Officer permit. Page 1 and 2 should be filed with Department of Health and Mental Hygier Important: If item 27 is marked other any injury or other traumatic event, thoose. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Hogston Georgia Keller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimberly Reyes, daughter 14520 Antigone Drive. North Potomac, Maryland 20878 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Loudon Park Crematory 9/29/2011 4 Donation 5 Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service deensee 22. Name and Address of Facility Simple Tribute 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ CVA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page performed? death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Tyes 2 X No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify HOSPICE မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at 5 Pending injury work after death. 1 ☐ Yes 2 ☐ No Accident Suicide Investigation the within 24 hours after d.

To the Funeral Directo. 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a, Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🔀 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29c. License numbe 29d. Date signed (Month, Day, Year)

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

R143201

Rockville, Maryland 20855

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OCTOBER 2011 2:45P.M1. Simon Edward Snyder Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Reeders Memorial Home Washington Boonsboro 8. Date of Birth (Month, Day, Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Min. **M** M 2 □ F (Month, Day, Year, 10/9/1922 Hours **Director** 216-14-6578 Virginia Usual Residence of Decedent in and Mental Hygtene. ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 417 Belview Ave. 21742 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 No If Yes, Give Black, White, etc. 1 Never Married 2 Married ð Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed Year or Dates White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Owner / Operator Percussion I and 2 should be filed w f Health and Mental Hygi item 27 is marked othe Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Simon C. Snyder Summers Cora 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr <u> Margaret J. Snyder / Sp</u>ouse 417 Belview Ave., Hagerstown, 20a. Method of Disposition

1. Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Rest Haven Cemetery 10/8/2011 | Hagerstown, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ilysician/ MULTIPLE MYRLOMA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Month 1 Yes 2 No ed by the a detached t g Unknown as been signed by 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by MYPERTENSION Chronic KIDNRY DISEASE 1 Yes 2 No 3 Probably 4 Unknown DHABRIES MALKITUS TYPE I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas DEMENTIA autopsy performed Yes 2 this certificate 1 Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No ျှ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 24 hours after death Funeral Director: filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) -att mo D18019 OCT 6, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VASANT DATTA, 340 MILL STREET, HAGERSTOWN, MARYLAND 301-739-7100 21740

State Registrar 31. Date filed (Month, Day, Year)

OCT 14 201

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2, Date of Death Physician/ SEPTEMBERDay 22 2011 9:23 P M В. JOHN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death ST. MARY'S CHARLOTTE HALL CHARLOTTE HALL VETERANS HOME Social Security Number 6 Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 XM 2 □ F Days Hours NOV. 27 579-40-4771 Vrs WASHINGTON, DC **Director** 1921 89 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No PRINCE GEORGE'S WASHINGTON MD 10e. Street and Number ō 10g. Citizen of What Country? ed other than "natural", or items 23a or event, the Medical Examiner must be Funeral USA 12614 LAGRANGE COURT 20744 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: AFRICAN AMERICAN 1 ☐ Yes 2X No Specify 3 Nidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired)

POLICEMAN I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) GOVERNMENT should be filed with and Mental Hygien is marked other to Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ARTHUR SWANN SR. 2 MONTRUELA HARDEN injury or other traumatic 1 and 2 should be of Health and Meintern 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, LAGRANGE COURT FOURT WASHINGTON, MD 20744 JACQUELINE R. BLAND/DGT 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place, ARLINGTON, VIRGINIA ARLINGTON NAT'L CEMÉ. 10/31/2011 22. Name and Address of Facility J. 3. JENKINS FUNERAL ROME, INC. 21. Signature of Funeral Service Licensee 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 Reene 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final Onset and Death Physician/ PROSTATE disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examin Cause (Disease or iinjury that initiated events resulting in death) Last that the death certificate be executed and trar Due to (or as a consequence of): nding physician ause as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Year Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by IMER'S DEMENTIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed death? Yes 2 No Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) 2 - No Other: 1 Tes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending injury 24 hours after death. Funeral Director: A 1 🗌 Yes 2 🗌 No the f Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 \square Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed 3 🗆 within 2. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0067788 123.2011

Registrar

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State

14090 HG TRUEMAN RD SUITE 2300 SOLOMONS, MD 20678

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KODALI

32. Regis

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SEP 2 8 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? State Registra Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ SEPTEMBER Day 2011 25 4:50 PM HORACE SPENCER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** ST. MARY'S CHARLOTTE HALL VETERANS HOUSE CHARLOTTE HALL Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday **Funeral** 1 X M 2 □ Hours JAN 23 1923 MARYTAND Director 88 217-18-8600 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 TyrYes 2 No MD PRINCE GEORGE'S UPPER MARLBORO 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20772 5301 MOUNT AIRY LANE 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 NoMAR If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married 2 NoMARINES 3altimore, Maryland 21215-0036 BLACK 1 ☐ Yes 2X No Specify: Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) GOVERNMENT SUPPLY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ THOMAS ALLEN SPENCER SARAH BELL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 5301 MOUNT AIRY LANE UPPER MARLBORO, MARYLAND 20772 MARY E. SPENCER/WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State MD VETERANS CEMETERY! 10-3-2011 CHELTENHAM, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) J. B. JENKINS FUNERAL HOME, INC. Signature of Funeral Service Licensee 22. Name and Address of Facility 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate lure. List only one cause on each line Onset and Death Immediate Cause Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, f any laboling to immedia cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of sician and burial-transit Exami that initiated events Due to (or as a consequence of) resulting in death) Last been signed by the attending physician should be detached for use as the burial Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 Live Birth
4 Pregnant a
9 Unknown in the past 12 months? Month Year Pregnant at time of death Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 DINO Completed 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe 1 ☐ Yes 2 ☐ No 2 DN To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director; I Be Was case referred to medical 26. Place of Death @heck only one) examiner? Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manney of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 Tyes Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 🔲 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Dertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Charlotte Itall 8 2011 31. Date filed (Month. State

Registrar

SFP 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 32865 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 0249 MITH Month P 2ay 2011 ma Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 1927 Brooks Drive, #101 Prince George's Heights Capitol 5. Social Security Number 7. Age (In vrs. last hirthday 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Days Mir 1 🗆 M 2 🖊 F Hours 71 231-50-7707 Yrs. Director /29/1940 Usual Residence of Decedent or 28a-f show notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No Capitol Heights MD Prince George's 10e. Street and Numbe 10f. Zip Code ō 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral United States 20743 1927 Brooks Drive death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify. Specify: 3 Widowed 4 X Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry المالية المال (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Private 12 should be filed with lith and Mental Hygien 27 is marked other the r traumatic event, the <u>Home Health Ai</u>de Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Frances Elizabeth Staten Valmore Wilcox, Sr. 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1855 Photina Street, Sumpter, SC 29154 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Nikia Crump/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🛣 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other Specify) 10/1/2011 Landover, Maryland Memoria1 22. Name and Address of Facility Fope Funeral Homes, P.A. 21. Signature of Funeral Serv 5538 Marlboro Pike, Forestville, Md 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause or each line. Approximate Immediate Cause (Final Onset and Death Ph_sician/ disease or condition Medical resulting in death) Due to (r as a consequence of) Examiner Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Due to (or as a sunsequence of). Examir Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events and tran Due to (or as a consequence of): resulting in death) Last inding physician a Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death Unknown the 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autonsy performed death? 2 🗌 No Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 1 🗌 Yes 2 - No |은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending s ar er death. Il Director Afi ed ir by th∈ fu 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie Date signed (Month, Day, Year) Jember 22 2011 21438

State

31. Date filed (Month, Day Year)
SEP 2 8 2011

32. Registrate Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

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	State of Maryland / Dena	rtment of He	alth and Menta	l Hygiene

•	1- For State Certificate of Death Reg. No.
Physician Medical Examine	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Prince Georges Hospital 4c. County of Death Prince George's
Funeral Director	5. Social Security Number 579-70-2782 6. Sex 7. Age (In yrs. last birthday) 1 Age (In yrs. last
any .	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
faryland 28a-f show any Latonce. ector	MD PRINCE GEORGE'S LANDOVER 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
h the Maryland 3a or 28a-f sho cotified at once.	7919 ALLENDALE DRIVE 20785 USA
fter death with the Maryland I", or items 23a or 28a-f sho ter must be notified at once. V Funeral Director	
y, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must he notified at once To Be Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) TRUCK DRIVER 16b. Kind of Business/Industry 17b. Kind of Business/Industry
21215-0036 ould be filed within 7 of Mental Hygiene. I marked other than ic event, the Media To Be Comple	WILLIE FLOYD SMITH SR. JUNE MEGGINSON
	19a. Informant's Name/Relationship (Type, Print) GARON SMITH/SON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7919 ALLENDALE DRIVE LANDOVER, MARYLAND 20785
	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of cemetery, crematory or other place) RIVERDALE CREMATORY 20c. Location - City or Town, State RIVERDALE, MARYLAND
Baltimo permit. Page Department of Important:	21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785
Physician /Medical Examiner	23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure List only one cause on each line. Approximate Interval Between Onset and Death Death Death Death
	Sequentially list conditions, b.
ted Insit Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):
xecuted and transit	d
ision of Vital Records, P.O. Box 68760, Attending Phyrician: The law requires that the death certificate be executed reath. extor: After this certificate has been signed by the attending physician and by the fineral director, page 2 should be detached for use as the burial—transication: To Be Completed by Physician/Medical E.	
, P.O. Bures that the disigned by the be detached do by Phy	
Division of Vital Records, P.(Lai or Attending Physician: The law requires tha rs after death. al Director: After this certificate has been signed led in by the funeral director, page 2 should be det erification: To Be Completed by	24a. Was an autopsy findings available prior to completion of cause of death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
Vital I hysician: this certification.	25. Was case referred to medical examiner? 1 Ves 2 No 1 No
ion of Verticeding Ph. ceath. the funeral the funeral attion: T	27. Manner of Death 1
Divi	Accident Investigation 3 Suicide 4 Homicide Homicide Specify Specify Suicide Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State) Martin Luther King Hgwy. Prince George's County Hgwy. Prince George's County Hgwy. Prince George's County Hgwy. Prince George's County Hgwy. Prince George's County Hgwy. Prince George's County Hgwy. Prince George's County Hgwy. Prince George's County Hgwy. Prince George's County Hgwy. Prince George's County Hgwy. Prince George's Count
Di To the Hospital within 24 hours at To the Funeral completely filled	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
To with To con	29b. Signature and title of certifier 29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) October 3, 2011
	30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223
State Registral	31. Date filed (Month, Day, Year) OCT 0 6 2011 August 5. Agards

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ SEPTEMBER 24 2011 8:50 PM CAROLYN LEE STAPLES Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yes Sept. 27 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Days Hours 61 Maryland Yrs Director 218-54-7041 1949 Usual Residence of Decedent 28a-f shov 10a. State 10b. County at 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 1 🗌 Yes 2 🔀 No Maryland Frederick Frederick ō 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 9716 Hansonville Road 21702 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or þ 1 Never Married 2 X Married 1 Yes : Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Completed 3 Widowed 4 Divorced White Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Analyst Food and Drug Admin. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Lelia Shaw Roger Staples 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9716 Hansonville Road, Frederick, Maryland 21702 George Kaas / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 K Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory Inc.9/30/2011 Frederick, Maryland. 21. Signature of Juneral Service Lice Stauffer Funeral Homes P.A. Opossumtown Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying use as the burial-transit Mematrox Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last physician Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?

1 Yes 2 No Pregnant at time of death Day been signed by the should be detached g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 🏲 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No page 2 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No Division of Vital funeral director, 26. Place of Death (Check only one) Be Hospital မ 1 X Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending Accident within 24 hours after death.

To the Funeral Director: Ai
completed filled in by the fu 1 Yes 2 No Investigation Suicide 6 Could not be 3 □ Sulciae 4 □ Homicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NEFLIL 400 W 7th 31. Date filed (Mo Registrar's Signature State Registrar

State Registrar Sharmila Aryal.

29

DHMH 17 Rev 7/2009

10810 Connecticut Avenue, 2nd floor, Kensington, Maryland 20895

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 20 1 3 2 8 6 9 State of Maryland / Department of Health and Mental Hygiene

			1- For State Registrar	•	Cei	rtificate of	Death		Re	eg. No.			
	ysici	an/	Decedent's Name (First, Midd		Date of Deat Month	Day Year	3. Time of Death						
Medical E	:xamı	ner			thleen		toltzfus		October 1	, 2011 4c. County of Dea	2100 hrs		
			4a. Facility Name (if not institution Civista Medical Center	· -	er)	1	lb. City, Town, o La Plata	or Location of D	eam	Charles			
Fu	neral	1	5. Social Security Number		Age (In vrs. I	ast birthday)	If Under 1 Ye	ar If Under 24	Hrs. 8. Date of Birt	th (MM/DD/YYYY) 9. B	irthplace (State or		
	ector		212-81-7067	1 M 2 X F		12 _{Yrs.}	11 11 1 11		Min. August		ign ountry) Maryland		
		ii.	Usual Residence of Decedent			110.							
	any		10a. State 10b. County		10c. City,	Town or Locati	on				10d. Inside City Limits		
and	28a-f show d at once.	5	Maryland Cha	arles	Mec	hanicsv	ille			1 Yes 2 No			
Maryl	28a-i	Director	10e. Street and Number				10f. Zip Code		10	0g. Citizen of What Co	untry?		
h the	3a or	₫	10185 Brooklin	ne Road			L :	20659		USA			
5 72 hours after death with the Maryland	or items 23a or 28a-f sho must be notified at once.	Funeral	11. Marital Status 1 X Never Married 2 M	12. Was Decede					(Specify Yes or No- erto Rican, etc.)	 14. Race - Ame White, etc. 	erican Indian, Black,		
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21215-0036 wld be filed within 7 Mental Hyoiene	narked event,	B		. Stoltzfus					Mary Host				
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, MD ind 2 sho	tant: If item 27 is marked or other traumatic event,		Melvin S. Sto	ortzius/fatr		Place of Disposi			Date	20c. Location - City of			
Baltimore, permit. Pages 1 ar Department of Hea	the E		1 X Burial 2 Cremation	n 3 Removal from		crematory or oth	er place)				·		
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Balti permit. Departm	Important: If item 27 injury or other traum		21. adilature of Fulleral Se	Sanding		M:	attingle	ev-Gardi	iner Fune	ral Home,	P.A.		
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/Ma	dical	0 0	failure. List only one cause Immediate Cause (Final disease	N. G 142	es						Between Onset and Death		
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X 6	attending for use as t	i <u>S</u>	past 12 months? 1 Yes 2 No 9 Uni	dinama '=	at time of de		er (Specify)						
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of Vital Records, 3g Physician: The law requin	1as 2 s	Completed		-					autop		completion of cause of		
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D C ding		Ë	1 Natural 5 Pend	(Month Day	y,Year)	1941 hrs	· · I _ ·	Yes 2 ✓ No	Subject pass		struck by truck and		
Division tal or Attendir rs after death.	rector:	<u>ia</u>		estigation 28e. Place of	Injury - At ho	ome, farm, stree	t, factory, office	building, etc.			Rural Route Number, City		
ital of	filled in by	Certification:		old not be ermined (Specify) N	lajor Road	d / Highway			or Town, S MD Route 5 a	itate) t Mt Wolf Road, Cha	arlotte Hall , MD		
Division of Vital Records, P.O. Box 68' To the Bospital or Attending Physician: The law requires that the death certif	To the Funeral Director: completely filled in by the		29a. Certifier (Check only 1 Certifying P	Physician: To the best of					and due to the caus	e(s) and manner as sta	ated.		
Fo the	To the Fur	Medical	one) 2 Medical Exa	aminer: On the basis of ex and manner state		nd/or investigati			ed at the time, date				
		Ž	29b. Signature and little of certifie	5/1. 6	7/7	1/20	/	se number		29d. Date signed (M			
			Ouls 2 1	Taller &	reed	42	0.0	.M.E.		October 2, 2011	l		
Sura		Ì	30. Name and address of person			•	Baltimore	Street Dalk:	more MD 2422	23			
<u> </u>			Victor Weedn MD JD		trar's Signatu			oneer, Balti	more, MD 2122				
R	St	ate	31. Date filed (Modifically, Xear)	2011 Zenegisi	a s signatu	The second	es!						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes for State Registrar 32870 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month i O 0500 M NILLIAM OMPSON 2011 Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug 9 1968 **Funeral** 9. Birthplace (State or Foreign 216-64-9043 1. M 2 - F 43 Maryland **Director** Usual Residence of Decede 28a-f show "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Kent Chestertown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 32 Schooner Way 21620 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death \text{Department of Health and Mental Hygiene,} Important; If item 27 is marked other than "natural", or items almy Injury or other traumatic event, the Medical Examiner mu once. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, rmed Forces? Black, White, etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates Black 1 Yes 2 No Specify 3 Widowed 4 Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Self-employed Stone Mason Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) 2 William H. Thompson, Jr. Margaret Etta Graves 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Ann Thompson (wife) 32 Schooner Way Chestertown, MD. 21620 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State ☐ Burial 2X Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Domation 5 Other (Specify) Kent Cremation Services 10/7/11 Smyrna, DE. ^{22. Name and Address of Facility}
Galena Funeral Home of Stephen L.
118 West Cross St. Galena, MD. 21 M00510 Part 1. Ep enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate shock, or heart failu Immediate Cause (Final Interval Between Meet and Death METASTATIC Physician/ ERITONEAL MES OTHELIOM A disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of, burial-trar and that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician Id be detached for use as the buria Physician/Medical the Hospital or Attending Physician. The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year 1 ☐ Yes ∠ L g ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ within 24 hours after death.

To the Funeral Director: After this certificate has been signompletely filled in by the funeral director, page 2 should I 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 2 No Yes 2 No 1 Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 10 ည 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 [only one) 29c. License number 29d. Date signed (Month, Day, Year)
Octure 06 2011 ပ 0 21438

Registrar DHMH 17 Rev 06-2011

State

MICHAE 31. Date filed (Month, Day,

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EFENSE HWY ANNAPOLO MOLIYOI

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OCT

Registraris Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 23. 2011 Bernice E. Tyre 10:00 AM Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Number 8. Date of Birth
(Month, Day, Year)
Sept. 24, 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🖾 F Months Hours Min. Director 577-28-9141 Yrs Sept. 1918 DC Usual Residence of Decedent or 28a-f show notified at 10a. State with the Maryland 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Tryes 2 No DC Washington 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 1825 Maryland Avenue NE 20002 United States and 2 should be filed within 72 hours after death we Health and Mental Hygiene. tem 27 is marked other than "natural", or items other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Armed Force Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 African 1 ☐ Yes 2 No Specify. Specify: American 3 🗆 Widowed 4 🗆 Divorced Completed 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ item 27 is marke other traumatic Victoria I. Stewart James E. Tyre 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 20877 8308 FairHaven Drive Gaithersburg, Md. Brenda H. Gilchrist - Cousin 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a Department of H Important: If ite any injury or otl Date 20c. Location - City or Town, State 1 ABurial 2 Cremation 3 Removal from State September 29, 2011 4 Donation 5 Other (Specify) 01ivet 2011 Washington, DC Signature of Funeral Service Licenses 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner t (or as a consequence of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner Due to (or as a consequence of) attending physician and I for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part L 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2-No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Other: ၉ 1- Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Menth, Day, Year) D0064024 26 2011

State Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause

SEP 2 8 2011

32. Registrar's Signature

Print A, M. D.

20912

Maryland 7600 Carroll Ave. Takoma Park,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygien ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 26, 2011 Physician/ E. Thomas Kenneth 10:07am Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) If Under 24 Hrs **Funeral** Month Hours 577-46-5238 **Director** 1 🗓 M 2 🗆 F 77 July 27, 1934 Washington, DC Usual Residence of Decedent 28a-f show 10b. County aţ 10a. State 10c. City, Town or Location 10d. Inside City Limits Director notified Maryland Montgomery 1 🗆 Yes 2 💢 No Silver Spring 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? or than "natural", or items 23a on the Medical Examiner must be Funeral 3122 Gracefield Road. 20904 U.S.A. within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 🔀 Yes 2 🗌 No 1958-13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, African-American 1 Never Married 2 X Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify 3 Widowed 4 Divorced 1982 Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Secondary (0-12) alth and Mental Hygien 127 is marked other the er traumatic event, the Tech Dun Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname 1 and 2 should be fi f Health and Mental ည Edward Thomas Elsie Copenina 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other to Martha Anne Thomas - Spouse 3122 Gracefield Road, #621, Silver Spring, MD 20904 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burlal 2 Cremation 3 X Removal from State Arlington Natl. Cem. 01/09/2012 4 Donation 5 Other (Specify) Arlington, Virginia Signature of Funeral Service License 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. M1564 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cardiopulmonary Arrest disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Gastric Cancer Sequentially list conditions, Examine Due to for as a consequence of flully, leading to immediate cause. Enter Underlying attending physician and I for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 Yes 2 No 3 Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? After this certificate 1 Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical completely filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? 2 X No Other: Certificate: To 1 Yes 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 2 🗌 No within 24 hours after death
To the Funeral Director: A Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only of Ertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signat D65069 1100 September 26, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road, Silver Spring, Maryland 20910 Sirak Lemma, M.D., Date filed (Month, Day, Year, State

Registrar

SEP

29

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			= State	partment of Health and Ne <i>rtificate of Death</i>		L. O 1 1	32873
			Registrar 1. Decedent's Name (First, Middle, Last)	or mode or beauti	2. Date of Dea	Reg. No.	3. Time of Death
	/sicia		Vincent Ralph Tayman Sr.		Month October	Day Year	1:00 a.M.
	Medic amin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	TOCCODEL	4c. County of Death	11.00 a.m.
ممي			37564 Chaptico Road	Chaptico		St. Mary'	s
Fun	eral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday		8. Date of Birth	h g. Birth	place (State or Foreign
Dire	ctor		212-20-0884 87	World Days Hours Will.	09/20/1	, Year) Cour 1924 Mary	land
pu pow	at	ž	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I	_ocation	<u> </u>		10d. Inside City Limits
laryla 3a-f s	ified	ecto	Maryland 9590 Nort	th Dryngrid 11 o Dood			1 ☐ Yes 2 🛣 No
the M or 28	e not	Funeral Director	10e. Street and Number	th Ryceville Road 10f. Zip Code		10g. Citizen of What Cou	ntry?
with \$23a	nst b	era	Mechanicsville	20659		United Stat	es
death items	ler m		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	B. Was Decedent of Hispanic Origin? (Sport of Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Americ	can Indian,
after of ", or	amir	þ	1 Never Married 2 Married 1 Yes 2 X No	1 ☐ Yes 2 🗓 No Specify:	riiodii, oto.j	Black, White,	etc.
ours attural	edical Examiner must be notified at	Completed	3 ▲ Widowed 4 □ Divorced Year or Dates.			Wh	ite
Z1Z15-UU36 within 72 hours after giene. er than "natural", o	Medic	ם	(Specify only highest grade completed) (Giv	edent's Usual Occupation re kind of work done during most of work DO NOT use retired)	ing	16b. Kind of Business In	dustry
within giene.	the		Elementary/Seconday (0-12) College (1-4 or 5+)	tenance Worker		National Pa	rk Service
	event, the Medical		17. Father's Name (First, Middle, Last)	18. Mother's Nam			
rarylan should be fill and Mental is marked o	atic e	욘	James Ralph Tayman	Janette	Clara J	Tenkins	
Maryland 2 should be filed th and Mental Hy ?7 is marked oth	or other traumatic	- 1	19a. Informant's Name/Relationship (Type, Print)	iling Address (Street and Number or Run	al Route Number	; City or Town, State, Zip	Code)
	thert			4 Chaptico Road, Cl			
Page 1 anent of fi	or of		1 🛣 Burial 2 □ Cremation 3 □ Removal from State cemetery, cr	ematory or other place)	Date	20c. Location - City or T	
Baltimore, permit. Page 1 and Department of Hes Important: If item	injury			's Piscataway 10/0			
balt permit. Departr Imports	any ir once.		VILLEN	Br: 22955 Hollywood Ros	insfield	l Funeral Ho	me, P.A. 20650
		7	23a. Part 1. Enter the disease, or complications that caused the death. Do not en	and the second s			Approximate
Ph sic	ian/		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	1	. 1 100		Interval Between Onset and Death
Med	lical		disease or condition resulting in death) a. Due to (or as a consequence of):	after pulmoner	2 onje	ey -	you
Exam		١	Sequentially list conditions.			45	
D :	±	ine	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying				
ecute and	-trans	xau	Cause (Disease or iinjury that initiated events c				
be ex	buria	dical Examiner					i i
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certific	nse a	<u> </u>	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1	Пен		23d. Date of deliv	very .
death of atter	od for	sicie	1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)		Month	Day Year
t the c	tache	Physician/Me	9 🗆 Unknown				
ss tha	pe de	þ	Part II. Other significant conditions contributing to death but not resulting in the TS Aurice heart Ms.	e underlying cause given in Part I.	V	bacco use contribute to t	
equire een s	pourd	eted	4300000 10-47 0003 SQC				bably 4 🗌 Unknown
e law requires	e 2 s	Completed by			24a. Was a autop perfor	sy prior to co	ppsy findings available empletion of cause of
The ficate	ir, pag		25. Was case referred to medical	20 81 48 11 49	1 L Yes		2 🗆 No
ysician s certifi	Irecto	o Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpati	26. Place of Death (Chec	/ /	0 FZ 00 - 10 - 11	Son Sence
g Phy g Phy er this	eral		27. Manner of Death 28a. Date of injury 28b. Time	of 28c. Injury at		ence 6 💢 Other (Speciform ow injury occurred)	w Kesidence
endin eath.	e fun	icat 	1 X Natural 5 ☐ Pending (Month, Day, Year) injury 2 ☐ AccidentInvestigation	work? M 1 ☐ Yes 2 ☐ No			
I or Attendir after death. Director: Af	ا ا	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Si City or Town	treet and Number or Rura	l Route Number,
Dital cours at seral Disast	lled I		Y				
Hose 24 hg	eted	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death (Check 2 Medical Examiner: On the basts of examination and/or inve	actication in my aninian death accurred a	t the time alote or	ad alone and due to the or	weeks and manner stated
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Hospital or Attending physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending physician and the property of the control of the physician and the property of the control of the physician and	GE 00		only one) 3 □ Certifying Nurse Practioner: To the best of my knowledge 29b. Signature and tike of certifier 30. Name and address of person who completed ause of death (Item 23a) (Type, 31. Date filed (Month, Day, Year) OCT 0 6 2011 32. Registrar's Signature	29c. License number	se, and que to the	e cause(s) and manner as s 29d. Date signed (Month,	Day, Year)
			1 / 1 / M	Do033424	0	10/3/11	
1			30. Name and address of person who completed ause of death (Item 23a) (Type,	Print)	,		1
le			B. LARRY JENKINS MD P.O. BO	x 2665 LaPlan	ta, MD	. 20646	
	State gistra	7	31. Date filed (Month,IDay, Year) OCT 0 6 2011 32. Fegistrar's Signature	back			
			401 4 - 2411 /7				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certifidate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 3mmEl 9:03 DM 2011 . Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death Examiner 4b. City, Town, or Location of Death HATEROH TIPUSUAN CURRINARY MAKUMA PARL Mani Gamer Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign Permisylvania If Under 24 Hrs. 8 Date of Birth **Funeral** Days 1 🕅 M 2 🗆 F FEBth, 201932 214-28-9177 Director Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Prince George's Adelphi Maryland 1 ☐ Yes 2 Å No 10e. Street and Number 10g. Citizen of What Country?
United States 10f. Zip Code 20783 Funeral 10108 Chickadee Lane 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give 1956-1958 1 ☐ Yes 2 X No Specify. White Specify "natural" 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) the Medical 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Graphic Artist Elementary/Seconday (0-12) College (114_0/45+) Government Be permit. Page 1 and 2 should be filed Department of Heatth and Mental Hy Important: If item 27 is marked ott any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) E**loise Moeller** ဂ္ Louis Walker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Boute Number, City or Town, State, Zip Code) 10108 Chickadee Lane Adelphi, Maryland 20783 Frances W. Walker -wife Baltimore, 20a. Method of Disposition 20h. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Alexandria, Virginia Metropolitan Crematory10/1/2011 4 Donation 5 Other (Specify) Signature of Euneral ervice Licens Boharia Vies Borgwardt Funeral Home, Maryland 20705 4400 Powder Mill Road Beltsville, 23a Part 1. Enter the disease, or condications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List of ly one cause on each line. Interval Betweer Immediate Cause (Final Onset and Death Physician/ MAKIDICLOUNC disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, but is cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner Due to for as a consequence of arte has been signed by the attending physician and page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 2 No 1 Yes Yes 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner eath 28b. Time of 28c. Injury at 28d. Describe how injury occurred atural 5 Pending work? 1 🗌 Yes 2 🗌 No ☐ Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b ionature and title of certifier -201 yn who completed cause of death (Item 23a) (Type, Print) Name and address of p MKung Park 31. Date filed (Month, Day, Year, 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 32875 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 201 Year 11:05 P M Medical HELEN IRENE 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick Frederick Memorial Hospital Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🎛 F Days Hours June 11, 244-90-3427 Year) **1952** 59 Yrs North Carolina Director Usual Residence of Deceden 28a-f shov notified at 10a State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Frederick Frederick 1 🔀 Yes 2 🗆 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? the Medical Examiner must be Funeral permit. Page 1 and 2 should be filed within 72 hours after death with. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatiitems 23a 2125-A Springwater Place 21701 United States of America 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Yes 2 No 1 ☐ Yes 2 No Specify. If Yes, Give Year or Dates White Completed 3 Wildowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Office Manager Security Card Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ပ Richard Eugene Peters Georgia Lucille Alphin 19a. Informant's Name/Relationship (Type, Print) **Tony Peters / Brother** 47 Colden Eye Lame, Port Monnouth, New Jersey 17758°00) 6125-A Springwater Place, Frederick, Maryland 21701 Melissa Ann West / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State October 13, 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg, Maryland Smithsburg Crematory 2011 Signature of Funeral Services 22. Name and Address of Facility Keeney & Basford P.A. Funeral Home 106 East Church Street, Frederick, Maryland 21701 M01433 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Leoci Medical resulting in death) Due to (or as a consequence of) **Examiner** DPRESS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner GRERS lastat cancer uran and Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial Physician/Medical The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Cartopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Day Year signed by the at d be detached for 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has 24 hours after death.

Funeral Director; After this certificate performe Yes 2 No 2 🗌 No 1 🗌 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: ဂ္ 1 Yes Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate:

Box 68760 P.O. Records. Division of Vital Hospital or Attending Physician:

Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: 10 the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nu ctioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

filled in by the

within 2.

Medical

31. Date filed (Month, Day, Year)

30. Name and address of pers

29b. Signature and tit

who completed cause of death (Item 23a) (Type, Print)

M: 32. Registrar's Signature

MDD

65378

29d. Date signed (Month, Day, Year)

Frederick mo

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Mary		tificate of L			Reg. N 2 0 1 1	32876
	Physicia	ın/	1. Decedent's Name (First, Middle, Last) Gloria Joanna Watso	n				2. Date of Deat		3. Time of Death
	Medic Examin		4a. Facility Name (if not institution, give stre			4b. City, Town, o	r Location of Death		4c. County of Dea	
-	·		Lorien Mount Airy			Mount			Carrol1	
	Funeral Director		5. Social Security Number 577-28-3870 Usual Residence of Decedent	7. Age (In y	rs. last birthday) 89 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth May 14,		thplace (State or Foreign untry)
	land show d at	호	10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits
	e Mary 28a-f notifie	Jirec	Maryland Carroll 10e. Street and Number		Mount					1 ※ Yes 2 □ No
	n with the Is 23a or nust be	Funeral Director	713 Midway Avenue			10f. Zip Code 2177	1		10g. Citizen of What Co United St	
9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.	Completed by Fu	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.	ŀ	Vas Decedent of H f Yes, specify Cuba ☐ Yes 2 🔀 No	ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: Wh	e, etc.
15-(72 hou n "nat fedica	nple	15. Decedent's Educa (Specify only highest grade o	tion completed)	(Give I	ent's Usual Occup	ation during most of work	king	16b. Kind of Business	Industry
212	within giene. er tha	Cor	Elementary/Seconday (0-12)	College (1-4 or 5+)		O NOT use retired) ressiona	l Aide		Federal Go	vernment
Maryland 21215-0036	d be filed Mental Hy, Irked oth tic event	To Be	17. Father's Name (First, Middle, Last) William Rocket				18. Mother's Nam Anna May	ne (First, Middle, M	Maiden Surname)	
, Man	id 2 should salth and N n 27 is ma er trauma		19a. Informant's Name/Relationship (Type, Barry Couzzo / Son-		19b. Mailin	g Address (Street a	and Number or Rur Monrovia,	ral Route Number,	City or Town, State, Zi	o Code)
Baltimore,	ge 1 ar it of He if iten or oth		20a. Method of Disposition 1 ☐ Burial 2 😾 Cremation 3 ☐ Rer	noval from State		natory or other place		1 /0011	20c. Location - City or	
altin	nit. Pa artmer oortant injury		4 Donation 5 Other (Specify) 21. Signature uneral Service Licensee	Re		Cremato	- /		Frederick,	
ñ	permit Depar Impor any in	12	1657		9	esthaven 501 Cato	Funeral ctin Moun	Services tain Hwy	s, Skkot Co v. Frederic	k, MD 21701
,	Physician/	1 15	23a. Part 1. Enter the disease, or complicat shock, or heart failure. List only one call immediate Cause Minal disease or condition	tions that caused the dause on each line. Alzheimer'			g, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death 1 Year
-	Medical Examiner		resulting in death)	Due to (or as a cons	equence of):					
	sit sd	ledical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a cons	equence of):					
	cate be executed physician and the burial-transit	Exar	that initiated events c resulting in death) Last	Due to (or as a cons	equence of):					
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687	attending p		IF FEMALE: 23b. Was decedent pregnant 23c.	If yes, outcome of pre					23d. Date of de	liven
Box	t the death by the atte	Physician/N	in the past 12 months?	1 Live Birth 2 F 4 Pregnant at time 9 Unknown		Ectopic pregnand Other (specify)	y .		Month	Day Year
s, P.O.	res that t signed b	þ	Part II. Other significant conditions contrib	outing to death but not	resulting in the u	nderlying cause giv	ven in Part I.		pacco use contribute to	the cause of death?
ord	aw require as been si 2 should	Completed						24a. Was ar	n 24b. Were au	rtopsy findings available
Rec	sician: The la certificate ha irector, page 2	Com						autops perform 1 \sum Yes	med? death?	completion of cause of
ta	nysician; iis certific director,	Be	25. Was case referred to medical examiner?	oital:		Otho	ace of Death (Chec	k only one)		
of V	Phys	e: 1	I LI Yes 2 124 NO	1 Inpatient 2 28a. Date of injury	28b. Time of	28c. Injury	4 🔼 Nursing He		ence 6 Other (Spec w injury occurred	eify)
ono	kttending l death. ctor: After y the funer	ficat	1 X Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day, Year)	injury	work	? Yes 2 No	EGG. POGGING NO	W Injury Goodined	
Division of Vital Records,	Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director. Here this certificate has been signed by the attending physician and sted filled in by the funeral director, page 2 should be detached for use as the burial-transit	al Certificate:	4 - Hormolde determined	28e. Place of Injury - At building, etc. (Spe	oify)			City or Town		
	To the Hospital or Atten Within 24 hours after deat To the Funeral Director: completed filled in by the	Medical	29a. Certifier (Check only one) 1 X Certifying Physician Check only one) 1 X Certifying Physician Check only one one of the check only one of the check only one of the check on the check of the check on the check of the check on the check of the chec	n: To the best of my kno On the basis of examina actioner: To the best of	tion and/or investi	gation, in my opinic	n, death occurred a	it the time, date an	d place, and due to the	cause(s) and manner stated.
	Voit Voit Con Con Con Con Con Con Con Con Con Con		29b. Signature and title of certifier	& ante	elx	29c. License			9d. Date signed (Mont.	
	以		30. Name and address of person who comp Robert G. Fenton, M			rint)	Clarksvil		-	
	Stat	е	31. Date filed (MoSEP Y2/8 2011	32 Hegistrar's Sig		exter	Tarks/11	.re, rm 2	. ± U ∠ J	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State Registrar	of Marylan		artment of I tificate of I		nd Men			32877
			Decedent's Name (First, Middle, Last)		007	inoute or i	Journ		Reg ate of Death		3. Time of Death
	Physici Medi		Raymond Cheves	Willia	ams				_{lonth} ptember	Day Year 201	.1 10:20p M
	Exami	ner	4a. Facility Name (if not institution, give street and n			4b. City, Town, o		Death		4c. County of Dea	ath
~~	-d		28935 Point Lookout F 5. Social Security Number 16. Sex	Road 7. Age (In yrs. Ia	ant histhday)	Lovev		4 Hm I a s	1 (2)	St. M	
	Funeral Director		217-36-9549 ^{1 ₺ M 2 □ F}		Yrs.	Months Days	Hours		ate of Birth Month, Day, Yes 10/24/19	9. B 038	rthplace (State or Foreign ountry) Maryland
	and show dat	٦	Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Loc	eation					10d. Inside City Limits
	larylar 3a-fs iffied	Funeral Director	Maryland St. Mary's	100.00		eville					1 Yes 2 X No
	the N or 2%	قَ	10e. Street and Number		100	10f. Zip Code	_		10g	. Citizen of What C	1
	s 23a uust b	ıera	28935 Point Lookout	Road		206	56			USA	,
	death item		11. Marital Status 12. Was De Armed	14. Race - Am							
336	al", or	d by	1 ☐ Never Married 2 ☒ Married 1 ☒ Ye 3 ☐ Widowed 4 ☐ Divorced Year or	Black, Whi	_						
9	hours natur Jical I	lete	15. Decedent's Education	o. Kind of Business	White Industry						
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121	d with tygier ther t	Be C	12 17. Father's Name (First, Middle, Last)		Po1	ice Offi				heriffs	Office
Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Manyland of Health and Mental Hygiene. filem 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Examiner must be notified at	To E	, , , , , , , , , , , , , , , , , , , ,	illiams			18. Mother's	,	, <i>Middle, M</i> aid .orine	Wright	
arZ	nould nd Me s mar umati		19a. Informant's Name/Relationship (Type, Print)	TTTTGIIIG	19b Mailin	n Address (Street				y or Town, State, Z	in Cade)
	id 2 sł salth a n 27 is ertra		Linda A. Williams/Spou	ıse	1					ille, MD	
ore	e 1 an of He If item		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal fro	20b. Pi	lace of Dispos	ition (Name of	-	Date		. Location - City o	
Baltimore,	t. Pag trment rtant: njury o		4 Donation 5 Other (Specify)	Met		atory or other place tan ory		9/30/2		lexandri	
Bal	permit. Page 1 and 2 Department of Health Important: If item 2: any injury or other tonce.		21. Santure of Funera Stry Light see	1 Home, I	P.A. 20650						
			23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on a	t caused the death	. Do not ente	the mode of dyin	g, such as ca	rdiac or respi	iratory arrest,		Approximate Interval Between
Z	Pnysician/ Medical	17	regulting in death)	Netastat		end ce	U Co	nism	ona		Onset and Death
Then.	Examiner		Due to	o (or as a conseque	ence of):						2 years
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	o (or as a conseque	ence of):						,
	cuted nd rransit	xam	Cause (Disease or iinjury that initiated events c								
_	cate be executed physician and s the burial-transit	edical Examiner	resulting in death) Last Due to	o (or as a conseque	ence of):						
760	cate by physics the b		d								
89	eath certifica attending p	N/N	20b. Was decedent pregnant	utcome of pregnan						23d. Date of de	elivery
Вох	death	Physician/M	1 Yes 2 No 4 Pre	e Birth 2 Fetal gnant at time of de known		Other (specify)	у			Month	Day Year
P.O.	that the des led by the s detached i		9 ☐ Unknown 9 ☐ Un Part II. Other significant conditions contributing to		Ilting in the un	derlying cause air	on in Port I		0 0:111		
S,	or Attending Physician: The law requires that the death certificate be executed after death. Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit	d by		dod in but not room	ating in the di	denying dade giv	erriiri airi.	2	3e. Did tobacc		or the cause of death? Probably 4 Unknown
ord	v requ	lete		· ·					4a. Was an	<u>/</u>	topsy findings available
3ec	The law ate has page 2 :	Completed							autopsy performed	prior to death?	completion of cause of
a	sician: The certificate l rector, page	BeC	25. Was case referred to medical examiner?			26. Pla	ace of Death	(Check only c	Yes 2 M	No 1	s 2 No
Ž	Physic this ce al dire	욘	1 Yes 2 VNo	Inpatient 2 🗆 E	R/Outpatient	3 DOA Othe	r: 4 🗆 Nursi	ing Home 5	K Residence	6 ☐ Other (Spec	cify)
n of	Attending P death. ctor: After t y the funera	Certificate:	1 ☑ Natural 5 ☐ Pending (Mo	e of injury nth, Day, Year)	28b. Time of injury	28c. Injury work	?		escribe how in	jury occurred	·
Siol	Attency deatl	<u>₩</u>	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place	e of Injury - At hon	ne farm stree		Yes 2 □ No		pation (Ctroot	and Mumber or Dr	ıral Route Number,
Division of Vital Records,	tal or as after all Direct ed in b		4 Homicide determined 286. Plac build	ling, etc. (Specify)	,,,	in actory, critico			ty or Town, Sta		rai noute Number,
	To the Hospital or Attendi within 24 hours after death To the Funeral Director: A completed filled in by the ft	Medical	29a. Certifier (Check conly one) 1 Certifying Physician: To the 2 Medical Examiner: On the base only one) 3 Certifying Nurse Practioner	asis of examination.	and/or investig	iation. In my opinio	n death accu	rrad at the tim	a date and nla	and due to the	called(e) and manner stated
	To the within To the Comp		29b. Signature and title of certifier	To the best of my	Knowledge, de	29c. License	_	id place, and		se(s) and manner as Date signed <i>(Mont</i>	
	<u>. </u>		March			D 00	0681	20		9-30	-1)
0	eno		30. Name and address of person who completed car	se of death (Item 2	23a) (Type, Pri	nt)			1 204		
F	Stat	_	31. Date filed (Month, Day, Year) 32.	egistrar's Signatu	ire						
	Registra	r	OCT 0 3 2011 \alpha	move ,	9. A.A.	wes					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Alfred Oliver Wildoner 28, 2011 Medical <u>September</u> 2:00 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 6410 Lamont Drive New Carrollton Prince George's Social Security Number If Under 1 8. Date of Birth (Month, Day, Year May 24, 1 **Funeral** 7. Age (In yrs. last birthday Year If Under 24 Hrs 9. Birthplace (State or Foreign 1 ϪM 2 🗆 F Months Hours Hunlocks Creek, PA **Director** 209-22-2436 81 1930 be filed within remove the state of the stat Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 X Yes 2 No Prince George's New Carrollton 10e. Street and Number 10g. Citizen of What Country Funeral 6410 Lamont Drive 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ģ 1 Never Married 2 Married 2 X No Yes Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Completed 3 X Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Plasterer Masonary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental I is marked o 2 Department of Health and Ment Important: If item 27 is marken any injury or and injury or any injury or any Oscar M. Wildoner other traumatic Blanche Pugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James A. Wildoner / Son 6122 85th Avenue, New Carrollton, MD 20784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 10/5/2011 Brentwood, Maryland Signature of Fymeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Dementia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Arthritis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami The law requires that the death certificate be executed Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last burialphysician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown 2 No signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 Yes 2 No 3 Probably 4 No Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe Yes 2 X No 1 Yes 2 No or Attending Physician: director. æ 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 X No Other: 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🖾 Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work?
1 Yes 2 No Accident
Suicide hours after death. neral Director: A filled in by the Investigation M 6 Could not be

Registrar

24 hours

within 2

npleted

Medical

Darryl A. 31. Date filed (Month, Day State 3 2011 OCT O

29a. Certifier

(Check

3 E

an

29b. Signature and title of certifie

4 - Homicide

determined

Hill, M.D., 13635 Baltimore Avenue, Laurel, MD 32. Registr

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29

29d. Dafe signed (Month, Day, Year)

11

			Plea	ase Type or Pr					-		Legible	
		For State		State of M	larylan		artment of H		Mental Hy	giene	0 1	32879
		Registrar 1. Decedent's Nam	o (First Middle	/ oot)		Cei	rtificate of L	Death	T	Reg. No.	011	
Physici				na Zaragoza					2. Date of De Month Septem		7, 201	3. Time of Death 5:41 P M
Medi Exami				, give street and number)			4b. City, Town, or	r Location of Death			County of Deat	
<u>/</u>				lospital				kville			Montgo	mery
Funeral Director		5. Social Security N 621-01-	-8918	6. Sex 1 ☐ M 2 🖾 F	ge (In yrs. Ia 40	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D May 5	rth ay, 1971		thplace (State or Foreign untry) dwin Park, CA
and show	5	Usual Residence of 10a. State	10b. County		10c. City	y, Town or Lo	cation	-				10d. Inside City Limits
Maryla 28a-f	rect	Maryland	Montg	omery	R	ockvil	1e					1 🔀 Yes 2 🗆 No
vith the 23a or st be no	Funeral Director	10e. Street and Nun		reet, #1			10f. Zip Code	0850			en of What Co	puntry?
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1	ied 2 🛭 Marr	12. Was Decedent Armed Forces? ied 1 Yes 2			Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Sp un, Mexican, Puerto		- 14	4. Race - Ame Black, White	e, etc.
ours a ntural'	eted	3 Widowed		If Yes, Give Year or Dates.			1 XX Yes 2 □ No		cican	Sį	pecify: Hi	.spanic
n 72 he e. ian "na Medic	Completed	(Spe	cify only highe	nt's Education st grade completed) College (1-4 or	5.1)	(Give	dent's Usual Occup: kind of work done o O NOT use retired)		king		d of Business	Industry
d withi ygiene her th	0	9			3+)	Ret	ail Cler	k		Re	etail	
ld be filex Mental H arked ot atic ever	To B	17. Father's Name (18. Mother's Nan Nancy (ne <i>(First, Middle</i> Gonzalez		ımame)	
shou h and 7 is m raum		19a. informant's Na			- 7	1	ng Address (Street a					
and 2 Health		20a. Method of Disp		agun / Son	20h P		Monroe St	treet, #J			ation - City or	
Page 1 nent of nt; If i		1 🗆 Burial 2 l 4 🗆 Donation		3 Removal from State	C	emetery, cren	natory or other place		Date 8/2011		•	Virginia
epartir porta ny inju		21. Signature of Fur			1		. Name and Addres	-	0, 2011			more Avenue
6 # 10 P	_	- Cyan	W	RAyRogus						Hyat	tsvill	e, MD 20781
		23a. Part 1. Enter the shock, or hear Immediate Cause (F	t failure. List o	complications that cause nly one cause on each lin	e.			. A		rrest,		Approximate Interval Between Onset and Death
Physician/ Medical		disease or condition resulting in death)		a. Due to (or as	a consequ	ence of):	encer	nalopa	ithy			Onder and Boath
Examiner	١	Saqueritially flet cor	oditions.	end:	stage	, ren	al disca	50				
ed sit	Examiner	if any, leading to im cause. Enter Under Cause (Disease or i	mediate lying	Due to (or as	a consequ	ence of):						
e executed sian and urial-transit		that initiated events resulting in death) L	· ′ ′	c. Due to or as								
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ertifica ding ph e as th	/Me	IF FEMALE:		000 16						-1		
Physician: The law requires that the death certificate this certificate has been signed by the attending physical director, page 2 should be detached for use as the	Physician/Medical	23b. Was decedent in the past 12 n 1 Yes 2 0 9 Unknown	nonths?	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal	death 3 [Ectopic pregnance Other (specify)	у		23	3d. Date of del Month	livery Day Year
requires that the de been signed by the should be detached	by PI	Part II. Other signifi	cant condition	ns contributing to death b	out not resu	ılting in the u	nderlying cause giv	en in Part I.	23e. Did t	obacco use	contribute to	the cause of death?
equires en sig ould b	ted I								1 🗆	Yes 2 🗆	No 3 🗆 P	robably 4 🖫 Unknown
law re nas be e 2 shr	Completed								24a. Was	psy	prior to o	topsy findings available completion of cause of
rsician: The law r s certificate has b lirector, page 2 sl		05.14								2 No	death?	2 □ No
l Physician: The lav ir this certificate has eral director, page 2	To Be	25. Was case referre examiner? 1 ☐ Yes 2 ☑		Hospital:		-2/0:	Othe	ace of Death (Chec er:			7	
ng Phy ter this neral c		27. Manner of Death		28a. Date of inju	ry	R/Outpatien 28b. Time of injury	28c. Injury	4 □ Nursing He	ome 5 L Resi 28d. Describe l			<u></u>
Attending er death ector: After by the uner	Certificate:	1 № Natural 2 ☐ Accident 3 ☐ Suicide	5 ☐ Pending Investige 6 ☐ Could n	ation				Yes 2 No				
alrAt saerd alDineci ediby		4 Homicide	determin			ne, farm, stre	et, factory, office		28f. Location (City or Tox		lumber or Rui	ral Route Number,
To the Hospital or Attending within 24 hours a let death. To the Funeral Director: After completed filled in by the funeral process.	Medical	(Check 2		Physician: To the best of aminer: On the basis of e Nurse Practioner: To the	xamination	and/or investi	gation, in my opinior	 n. death occurred a 	t the time, date a	and place, ar	nd due to the o	cause(s) and manner stated.
withi To th		29b. Signature and ti	tle of certifier	1 1			29c License	number		29d Date	signed (Month	Day Vearl
				nhad Mi	-		Doo	6+482		Septe	mber	28 2011
3		30. Name and addres	ss of person w	ho completed cause of d	eath (Item :	23a) (Type, Pr 9901	medica	1 centre	- Drive,	Pock	willty 1	28 2011 Maryland 20850
Stat	e_	31. Date filed (Month,	, Day, Year)	32. Registr	r's Signato	, , , ,	V	3 3 1 1 0 7		•		
Registra		NI 11 0 0	71111	A7 1 A	1	a. M. J						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 32880 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 0605 M Zoi Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death CN KIVER HESTER stes 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** Min 1.XM 2 □ F Director Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Yes 2 🗆 No 10e. Street and Number 10g. Citizen of What Country? Funeral 21 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 X Yes 2 No. If Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify If Yes, Give Year or Dates. Vietnam 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) ATWATER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 1Arenc 19a. Informant's Name/Relationship (Type, Print) Ohn 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Signature Fuperal Ser , or complications that caused the death. Do not enter the mode of dying, such as cardiac of List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): -transit and Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 1 Yes 2 g the cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has l completed filled in by the funeral director, page 2 s autopsy performed 2 No 1 Yes 25. Was case referred to medical examiner? Hospital or Attending Physician: 26. Place of Death (Check only one) Be 2 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work?
1 Yes 1 Natural 5 Pending 2 No Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature 29d. Date signed (Month, Day, Year) YXY address of person who completed cause of death (Item 23a) (Type, Print) 21620 31. Date filed (A

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death September 30, Physician/ 2011 2:55 PM M Dian L. Brown Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Crownsville Fairfield Nursing Center If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) May 7, 1942 Maryland Director 214-40-2363 1 □ M 2 🛚 F 69 Usual Residence of Dece 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Annapolis MD Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 21409 1676 St. Margaret Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Force Black, White, etc ģ 1 Never Married 2 Married Yes 2 No Saltimore, Maryland 21215-0036 white 1 ☐ Yes 2 💢 No Specify: If Yes, Give Specify: 3 ₺ Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry المالية المال (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) none disabled 2 should be filed with h and Mental Hygien 7 is marked other th Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) မ Doris Viola DelGuidice Francis Sigel Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 303 South Drive Severna Park, MD Howard Brown/brother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🗆 Burial 2 🗀 Cremation 3 🗀 Removal from State cemetery, crematory or other place) 4 X Donation 5 Other (Specify) State MARKETON Board 655 W. Baltimore Street 21201 Baltimore, MD Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ D/e to (or as a consequence of): disease or condition resulting in death) Medical Examiner Sementially list or or three Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a I for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Dav the Unknown g Unknown signed by 1 1 be detach 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has performed' ours after death.

eral Director: After this certificate I filled in by the funeral director, page 2 No Yes 2 No 1 Yes Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manney of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral C

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) ည

Registrar

Sw Glen Barnie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes O 1 1

			for State Registrar	ie or maryiano		tificate of D		ia ivientai r	nygleri Reg. N	ZUII	32882
	Physicia	ın/	1. Decedent's Name (First, Middle, Last) Lott	William	D	roun		2. Date of	Death	2, 20 řejr	3. Time of Death 6:15 AM
Jan.	Medic Examir		4a. Facility Name (if not institution, give street and		Б	rown 4b. City, Town, or	Location of D			c. County of De	
مرب	<i>}</i>		31 South Carolina Av	e.		Pa	sadena	à		Anne A	
	Funeral Director		5. Social Security Number 6. Sex 212-26-5597 1 🖾 M 2 [7. Age (In yrs. last	Months Days Hours Min				Birth <i>Day</i> , Yea <i>r)</i>	9. B C	irthplace (State or Foreign ountry)
	d t t	L	Usual Residence of Decedent 10a. State 10b. County	8.			July	03]	L928	MD	
	arylanda-f sh fied a	Director	Maryland Anne Arunde	10c. City, To	own or Loc	ation Pasad	dono				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	the M or 28	Ē	10e. Street and Number			10f. Zip Code	Jena		10g. 0	Citizen of What C	
	h with ns 23a nust b	Funeral	31 South Carolina Av	enue			21122			U	SA
(0	er deat or iten niner r	by Fu	Arme	Decedent Ever in U.S. ed Forces? Yes 2 X No	13. W	as Decedent of His Yes, specify Cuban	panic Origin? n, Mexican, Pu	? (Specify Yes or Nuerto Rican, etc.)	lo-	14. Race - Am Black, Wh	
99	ural", ural", Il Exar		If Ye	s, Give or Dates.	1	☐ Yes 2 💢 No	Specify:			Specify:	White
Maryland 21215-0036	within 72 hours after death with the Maryland grene. er than "natural", or items 23a or 28a-f sho er than Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade comp	leted)	(Give k	ent's Usual Occupa ind of work done du NOT use retired)		working	16b.	Kind of Busines	s/Industry
212	within giene.		Elementary/Secondary (0-12) Colle	ge (1-4 or 5+)		Sheet Meta	al			HVAC	
pu	d 2 should be filed vath and Mental Hyg 127 is marked othe r traumatic event,	To Be	17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Midd	lle, Maidei	n Surname)	
3	should b and Mer is mark aumatic	-	Lott W. Brown 19a. Informant's Name/Relationship (Type, Print)		10h Mallin	n Address (Otros to		Unkr		Taura Ctata 3	Zin Condo)
Š	d 2 sh alth ar 27 is er trau			(spouse)		g Address <i>(Street ar</i> South Car					
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal		e of Dispos etery, crem	ition (Name of atory or other place) 00	Date	20c.	Location - City of	or Town, State
<u>ti</u>	permit. Page of Department of Important: If any injury or once.	- 1	4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee			Cemetery		2011	-		Maryland
Ba	Depar Depar Impor any ir		Mischiel Dervice Licensee	all in or	.) 22.	Name and Address			_		Home, P.A. MD 21122
ı			23a. Part 1. Enter the disease, or consolications shock, or heart failure. List only one cause	that caused the death Don each line.	o not enter						Approximate Interval Between
~!	hysician Medical	1 1	Immediate Cause (Final disease or condition resulting in death)	Lung		7520					Onset and Death
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8760	rtificate ing phy e as th	Physician/Medical	IF FEMALE:								
Box 6	requires that the death certific been signed by the attending should be detached for use as	cian/	23b. Was decedent pregnant 23c. If yes in the past 12 months?	s, outcome of pregnancy Live Birth 2 Fetal de Pregnant at time of deat	eath 3 🗌	Ectopic pregnancy Other (specify)			- 1	23d. Date of d Month	elivery Day Year
O. B	the de by the tached	hysi		Unknown							
J.	law requires that the nas been signed by the e 2 should be detach	by	Part II. Other significant conditions contributing	to death but not resulting	ng in the un	derlying cause give	en in Part I.		,		to the cause of death?
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<u>a</u>	sian: T ertifica ector, p		25. Was case referred to medical examiner?			26. Plac	ce of Death (C	1 ∟ Ye Check only one)	es 2.401	NO] 1 16	es 2 Mo
<u> </u>	Physic this corral dire	은	1 Yes 2 No Hospital:	1 Inpatient 2 ER/	Outpatient		4 ∐ Nursin	ng Home 5 Re			ecify)
0 00	nding ath. r: After re fune	icate		Month, Day, Year)	injury	28c. Injury : work? M 1 🗆 Y		28d. Describ	e how inju	iry occurred	
Division of	or Atte fter de: irector n by th	Certificate:	3 Suicide 6 Could not be	Place of Injury - At home, building, etc. (Specify)	, farm, stree	et, factory, office			n (Street a		ural Route Number,
בֿ	spital cours a cours a leral D		29a. Certifier 1 Certifying Physician: To	the best of my knowledg	ue death or	coursed at the time	date and plac				stated
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical		e basis of examination and	d/or investig	gation, in my opinion	, death occurr	red at the time, dat	e and plac	e, and due to the	cause(s) and manner stated.
	Not to to to to to to to to to to to to t		29b. Signature and title of certifier	0.4	_	29c. License	number		29d. D	ate signed (Mon	th, Day, Year)
			30. Name and address of person who completed	cause of death (Item 23s	a) (Type Pri	int)) / 5	1 /	10	CTG521	-12,6011
	MV		(Kussell 66, De	Luca, ho	30	5 Hos	2. tol	D wes	(1/cn	Buny	2d-2606
	Stat Registra	-	31. Date filed (Month, Day, Year)	32 Registrar's Signature	bar	Ken !)	,		/-	4

11-07537 Zivan Bovd Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Ziyan Boyd	Į		. No. 2011 3288							
Physician Medical Examine		7 1. Decedent's Name (First, Middle,Last) 2. Date of Death Month October 8,	Day Year 0221 hrs							
\bigcirc	ı	4a. Facility Name (if not institution, give street and number) Johns Hopkins Hospital 4b. City, Town, or Location of Death Baltimore	4c. County of Death N / A							
Funeral Director			(MM/DD/YYYY) 9. Birthplace (State or Foreign Country)							
any	F	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits							
Aaryland 28a-f show 1 at once		MD N/A Baltimore 106. Street and Number 10f. Zip Code 10g	1 Yes 2 No							
3a or 28	Director		g, Citizen of What Country? USA							
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036 rithin 72 hours af sne. r. than "natural dedical Examin	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) N/A	16b. Kind of Business/Industry N/A							
21215-0036 uld be filed within 7. Mental Hygiene. marked other than c event, the Medical	S e Co		aiden Surname)							
MD 2121 nd 2 should be filth and Mental m 27 is marked aumatic event,		19a Informant's Name/Relationship (Type, Print) Robin Boyd/Grandmother 19b. Mailing Address (Street and Number or Rural Route Number of Rural Route Numb	er, City or Town, State, Zip Code)							
Baltimore, M permit Pages I and 2 Department of Health Important: If tiem 2 injury or other traun	- 1		20c Location - City or Town, State Balt., MS-MD							
Baltimore permit Pages 1 Department of F Important: If injury or other		21. Signature of Funeral Service Incensee 22. Name and Address of FacilityHari P. C. 5126 Belair Rd, Balt., N	18 ⁵ 21208 ² 5185							
Physician /Medical		23a. Part I. Enter the disease, or semplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arresfailure. List only one cause on each line.	st, shock, or heart Approximate Interval Between Onset and Death							
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Sudden Unexplained Death in Infancy (SUDI) Due to (or as a consequence of):								
		Sequentially list conditions, if any, leading to immediate								
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50, te be execu iysician and	Healical	▼ UNPENDED								
on of Vital Records, P.O. Box 68760, tending Physician: The law requires that the death certificate be executed or: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial - transition: To Bo Completed by Dhyseisian Madical E.		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of 1 Other (Specify) 9 Unknown	23d Date of delivery Month Day Year							
P.O. Besthat the despending by the detached	╗	1 Yes	acco use contribute to the cause of death? 2 ✓ No 3 Probably 4 Unknown							
Division of Vital Records, tal or Attending Physician: The law require its after death. al Director: After this certificate has been siled in by the funeral director, page 2 should be desired.	najaidiiloo	24a. Was an autopsy perform 1 ✓ Yes 2	y prior to completion of cause of death?							
tal Recision: The certificate ector, page		25. Was case referred to medical 26. Place of Death (Check only one)								
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Division o the Hospital or Attending hin 24 hours after death. the Funeral Director: Aft apletely filled in by the fune		3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, Sta Homicide 4 Homicide 4 Homicide (Specify) Found: Residence 28f. Location (Strong Town, Sta Baltimore)	ate) 1041 North Kenwood Ave							
	₫ .									
7 7 2	IME	29b. Signature and title of certifier 29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) October 8, 2011							
all Phi	-	30. Name and address of person who completed cause of death (Item 23a)								
Stat	e	Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month Day Yaar) 2011 Registrar's Signature								
Registra	7	31. Date filed (Morth Day Year) 2011 2011 Singular Signature								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 23a per dr., g920 Jenaring 10 Hengith and Mental Hygiene 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician Bullan 3clobe 4a. Facility Name (If not institution, give street and number) 2011 /Medical 4c. County of Death 4b. City. Town, or Location of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | May 27, 1949 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1**X** M 2 □ F 62 295-46-9710 Director Washington DC Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show Md. Baltimore Dundalk 1 ☐ Yes 25 No Director Examiner must be notified 10g. Citizen of What Country? 10e, Street and Number 10f. Zip-Code ö 7853 Wynbrook Road 21224 USA items 23a Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married ö Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White ģ 3 Widowed 4 Divorced "natural" Completed 16b. Kind of Business/Industry traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) than College (1-4 or 5+) and Mental Hygiene. 12 years 1 year Steelworker Dundalk Ornamental 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; If item 27 is marked oth any injury or other traumatic event, one. Be Robert Buzzard Ruth Creamer မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peggy Buzzard Wife 7853 Wynbrook Road, Baltimore, Md. 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State October 1 X Burial 2 Cremation 3 Removal from State Oak Lawn Cemetery Dundalk, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 10, 2011 21. Signature of Funer Serve Licens 22. Name and Address of Facility
Connelly Funeral Home Of Dundalk, P.A. MUIITO 7110 Sollers Point Road, Dundalk, Md. 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final **Physician** resulting in death) se or condition /Medical ue to (a as a conse us ce of): **Examiner** Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events. Examine Due to (or as a consequence of) physician and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Tectopic pregnancy in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) ∃Yes 2 □ No P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 2 No 3 Probably 4 Unknown 1 TYes ate has been sig page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 2 □ No 1 Yes 1 Yes Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 2 No 2 MER/Outpatient 3 DOA မ 1 Yes this 27. Manyler of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 M Natural 5 Pending investigation Injury after death. Director; Aft 1 Yes 2 No 2 Accident filled in by the 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou To the Fune completely fi Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number October 6,2011 165-000

State Registrar 30. Name and address of person who

yas 31. Date filed (Month, Day, Year)

500

DHMH 17 Rev 1/2001

4940 Eastern Avenue, Baltimore, MD, 21224

completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Bullock, Jr. Month Granville 12:58 P M ocrober Medical 4a. Facility Name (if not institution, give street and number) **Examiner** City, Town, or Location of Death 4c. County of Death Eldersburg 1810 H Vincenza Drive Carrol1 Social Security Number 8. Date of Birth (Month_Day, 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) PA Funeral 7. Age (In yrs. last birthday) 1 😾 M 2 🗆 F Days 214-30-2080 77 1934 **Director** Yrs May Usual Residence of Decedent 28a-f show "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Carroll Eldersburg 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral with USA 1810 H Vincenza Drive 21784 filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒️ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: white Completed 3 Widowed 4 Divorced er than "natur, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) barber barber and Mental Hygien is marked other t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be fil rtment of Health and Mental rtant: If item 27 is marked in njury or other traumatic ev ပ Ruth Leidy Granville W. Bullock Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1810 H Vincenza Dr., Eldersburg, MD 21784 Sharon Bullock (spouse) Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 10-18-11 Smallwood, MD 4 ☐ Donation 5 ☐ Other (Specify) Deer Park Cemetery Signature of Funeral Service Licenses 22. Name and Address of Facility Haight Funeral Home & Chapel Parox Harons oubert P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final END-Stay (andiomyopala Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? within 24 hours after death.

To the Funeral Director; After this certificate 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 🗆 🗚 6 Other: 1 Yes Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0057-465 10/14/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5203 Baltimore MDZ1209. KNI apakse , M.D. 2835

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Items 11,12,15-20c,22 per fh g920 10-19-11 yr. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day # 1:19 Medical 4a. Facility Name (if not institution, give street and nur Town, or Location of Death **Examiner** 4c. County of Death Baltimore Bou SELOU: 1 9. Birthplace (State or Foreign Country) unk Social Security Number 8. Date of Birth (Month, Day, Year Apr 25, 1 If Under 1 Year I If Under 24 Hrs. **Funeral** Age (In yrs. last birthday) 1 M 2 D F Months Min Hours 214-44-6512 **Director** 68 Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location must be notified at 10d. Inside City Limits Director 1 Yes 2 ☐ No MD Baltimore ь 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with to Department of Health and Mental Hygiene. Immortant: If item 27 is marked other than "natural", or items 23a, Important; It item 27 is marked other than "natural", or items 23a, any injury or other traumatic event, the Medical Examiner must be Funeral 1924 Harlem Avenue 21217 USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. ģ 1 Never Married 2 Married 2 No unk Baltimore, Maryland 21215-0036 1 X Yes If Yes, Give 1 ☐ Yes 2 🎇 No Specify: Specify: black 3 Divorced 4 X Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk unk 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Bethlehem Ship Fitter Be 17. Father's Name (First, Middle, Last) unk unk 18. Mother's Name (First, Middle, Maiden Surname) John Robert Crockett Leona Ballard 19a. Inf**grant's Tan**e-Relationship (Type, Print) Bon Secours Hospital 19b. Mailin**, A.9**es**Kahn**an **Dr.**mbe**Rikesvi**b Mes, Cit **Md**awn, State, Zip Code) 2000 W. Baltimore Street Baltimore, MD 21223 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Donater (Specify) King Memorial Park Baltimore, Md. 10-16-11 Sign/tu 1 Ronal d Name and Address of Facility Howell 5 Funeral Home 4600 Liberty Baltimore, MD Heights 21207 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate or heart failure. List only one cause on each line Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician OUTTO STIVE Medical Due to (or as a consequence of): Examiner 194 Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and the burial-tran Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No ☐ Live Birth ∠ ☐ , c.... ☐ Pregnant at time of death Month page 2 should be detached 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has after death.

Director: After this certificate 1 Tes 1 Yes 2 No completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or within 24 hours at To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year)

State Registrar and address of person who con

Year)

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31. Date filed (Month, Day,

BATTIMERU

leted cause of death (Item 23a) (Type, Print)

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Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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		For State		State	of Mar	yland			Health and	Mental Hy	giene	011	32887
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To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the	Medical	29a. Certifier 1 (Check 2	Certifying I	Physician: To the base	est of my	knowled	ge, death o	ccured at the time	e, date and place, a on, death occurred	and due to the ca at the time, date a	use(s) and m	nanner as stated	ted. ause(s) and manner stated.
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Mary A. Campbell <u>6:45₽</u>^M Oct 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Brinton Woods Sykesville Carroll 8. Date of Birth (Month, Day, Year)
Oct 31. Birthplace (State or Foreign Country) Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday, **Funeral** 1 □ M 2 🛣 F 90 Director 218-10-7610 Oct 1920 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 K No MD Carrol1 Woodbine 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2814 Haddaway Dr. 21797 United States 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by 1 Never Married 2 Married 2XXNo 1 Yes 2 X No Specify. and Mental Hygiene. If Yes. Give Specify: White 3X Widowed 4 ☐ Divorced Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Licensed Practical Nurse Siani Hospital of Health and Mental Hygi of Health and Mental Hygi fitem 27 is marked othe Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George E. Akehurst Emma Louise Hare 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wendy A. Gahm (Daughter) 2824 Haddaway Dr. Woodbine, MD 21797 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot Date cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 10/19/ 2011 Baltimore, Md 22. Name and Address of Facility
Burrier-Queen Funeral Home and Crematory,
1212 W. Old Liberty Rd. Winfield, MD 2178 2 a. Part 1. Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lind. Approximate Interval_Between set and Death Immediate Cause (Final Musey Physician/ disease or condition Medical resulting in death) as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of finjury that initiated events Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Exam Due to (or as a consequence of) resulting in death) Last Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Year Month g 🗌 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 🗌 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending injury work? 2 Accident
3 Suicide 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29c. License number 20806 2011 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
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Baltimore, Maryland 21215-0036

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Division of Vital

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2011 Physician/ October 8, 4:05 AM M <u>John M. Devoe Sr</u> Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Timonium Stella Maris Social Security Number 6. Sex Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Months Days Hours 216-30-7298 Director 1 🛛 M 2 🗆 F July 25, 1934 Maryland 77 28a-f show ms 23a or 28a-f shor must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🗓 No Baltimore Baltimroe 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5109 Thomas Avenue 21236 USA items 2 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 X Yes 2 I If Yes, Give Year or Dates. 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify white Completed 3 XWidowed 4 Divorced Specify: **'**52**-**54 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 4:05 (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4 or 5+) beverages brewmaster other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental h 2011 ပ္ Margaret Elizabeth Beinke James William Devoe 19a. Informant's Name/Relationship (Type, Print) Department of Health as Important: If item 27 is any injury or other treesonce 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5109 Thomas Avenue Baltimore, MD 21236 John M. Devoe Jr/son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State OCTOBER 1
Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) Signature of Funeral Se State and Address off Facility and 655 W. Baltimore Street Director Baltimore 21201 MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. For heart failure. List only one cause on each line. Approximate Interval Between Onset and Death shock Immediate Cause (Final Physician/ disease or condition GASTRIC CANCER Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami attending physician and for use as the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death Physician/ 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown g Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by JOHN DEVOE 2 No 3 Probably 4 Unknown 1 Yes Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed: 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 2 X No ည 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA HOSPICE 4 Nursing Home 5 Residence 6 Nother (Specify) eral Director: After this filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28d. Describe how injury occurred To the Hospital or Attending work?
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To the Funeral I

completely filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

JACKIE JONES, CRNP 2300 DULANEY VALLEY RD.

ss of person who completed cause of death (Item 23a) (Type, Print)

TIMONIUM, MD 21093

29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year)

29b. Signature and

30. Name and

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 4:13PM Terry Roxanne Dopkowski october 04 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Union Memorial Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yes Funeral Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 🗆 M 2 💢 F Hours Maryland Director 1958 214-72-5653 Sept Usual Residence of Decedent fshow 10c. City, Town or Location ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 Yes 2 No Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral USA 21215 2501 Violet Avenue 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc 1 Never Married 2 Married 3altimore, Maryland 21215-0036 white 1 Yes 2 No Specify: If Yes, Give Specify: and Mental Hygiene. is marked other than "natural", 3 🗌 Widowed 4 🔀 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)
Patricia Morrison ပ James Staggs 19a. Informant's Name/Relationship (Type, Print)

James Staggs/brother 19b. Mailing Address (Street and Number or Rural Boute Number, City or Town, State, Zip Code)
Owings Mills, MD 21117 Department of Health as Important: If item 27 is any injury or other trau 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗆 Burial 2 🗆 Cremation 3 🗀 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) in state Stare MARKETON Board 655 W. Baltimore Street Ronald Sicen Wale Baltimore, MD 21201 . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Wetastatic Lung Cancer years disease or condition Medical resulting in death) Examiner Effusion Sequentially list conditions Examiner If any, leading to immediate cause. Enter Underlying -transit Cause (Disease or iinjury that initiated events Pericardial Exfa death certificate be executed and Due to (or as a consequence of) resulting in death) Last physician a the burial-1 Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Pregnant at time of death signed by the a 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an No the nown within 24 hours after death.

To the Funeral Director. After this certificate has the funeral director, page 2 s Hospital or Attending Physician; The law autops performed?

Yes 2 No 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: (Month, Day, Year) Natural 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) October 4, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospital Baltimore, MD 21218 Varion State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 9:50 PM ctober 2011 Medical Name (if not institution, give street and number, City, Town, or Location of Death Examiner 4c. County of Death MNS Hookins tomore (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min. 80 4577 **Director** 49 1**X** M 2 □ F 251962 show 10a. State 10c. City, Town or Location Director notified 1

Yes 2 □ No 28a-f MO CARROLL 10e. Street and Number ö 10g. Citizen of What Country? ems 23a or r must be r Funeral ner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. Examin ō þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: Specify: WHITE "natural" Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) JOHNS HOPKINS than Elementary/Secondary (0-12) College (1-4 or 5+) of Health and Mental Hygiene item 27 is marked other that other traumatic event, the MANAGER APPLIED PHYSICS LAB ACE FLIGHTS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ DANTZLER SURRETT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) int of Health a t; If item 27 is or other trai 448 HAWKRIOGELANE NEI WANTZLER 20b. Place of Disposition (Name of cemetery, crematory or other place, ☐ Burial 2 Cremation 3 ☐ Removal from State Department of Important: If any injury or once. WINFIEW, MO 4 ☐ Donation 5 ☐ Other (Specify) BOUTH CARROLL GREM Signature of Funeral Service Licensee 22. Name and Address of Facility JN ZMBWN EHA MON Co. SYKESVILLE ROD ELIDERSBURGIMO 21784 Vart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a nonsequence signed by the attending physician and deetached or use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Dav 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 within 24 hours after death.

To the Funeral Director, After this certificate has autopsy perforr 2 🗌 No Yes Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes Other: ည 1 Inpatient 2 🗆 4 Nursing Home 5 Residence 6 Other (Specify ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 2 Accident 5 Pending 1 🗌 Yes 2 🗆 No Investigation filled in by the 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier RES-000 OCTOBER 14 person who completed cause of death (Item 23a) (Type, Print) WICKPAMASINGHE 600 North Worke Baltimoremdans

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 32892 Certificate of Death 1. Decedent's Name (First, Middle, Last 2. Date of Death 3. Time of Death Physician/ Medical Name (if not institution, give street and number 4c. County of Death **Examiner** Lity, Town, or Location of Death . Age (In yrs. last birthday 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, **Director** 1 M 2 K 78 Yrs Carolina 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 Yes 2 No 10g. Citizen of What Country? ò Funeral 23a 21213 ISA permit. Page 1 and 2 should be filed within 72 hours after death \text{Department of Health and Mental Hygiene.} Inportant: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Armed Forces? Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Be မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stat 2 Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 2 Cremation 3 Removal from State 5 Other (Specify) amenton. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of Approximate Interval Between Onset and Death shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Mysthema Physician/ Medical Due to (or as consequence of) Examiner Sequentially list conditions, if any leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dulis to Jorge eral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit that the death certificate be executed Due to (or as a consequence of): Physician/Medical mess acord P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Day Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed 2 1 No Yes the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 1 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No Natural 5 Pending after death. 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 7 29b. Signature and title of pertific 29d. Date signed (Month, Day, Year) ٥ D31464 10/13/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ST Suite 308 BALTIMORE MP 2/201 821 N. EYTAW A. HASKMIMD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State arke

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar		Certifica	te of L	Death			Reg	. No.		
Physicia		1. Decedent's Name (First, Midd	1111	0 /		17/5		2. Dat	te of Death			3. Time of Death
Medical Exami	ner	4a. Facility Name (if not institution	A'MIR	£	64	100			bber 13,	Day Year 2011		1330 hrs
						City, Town, or L	Location of D	eath		4c. County of		
		Frederick Memorial H	DSpital			Frederick				Frederick	(
Funeral		5. Social Security Number	6. Sex 7. Age (I	n yrs. last birth	day)	If Under 1 Year		2.01			Foreign	hplace (State or
Director		(UNK)	1 M 2 F		Yrs.	Months Days	Hours	Min.	UG 31	, 2010	Cou	untry) MI)
	ı	Usual Residence of Decedent										
, any		10a. State 10b. County		c. City, Town o)						10d. Inside City Limits
show	칟	MD FREC	1 ERICK	FRONLA	RICK	Walk.	ersvi1	10				1 Yes 2 No
ne Maryland or 28a-f show any fied at once.	兹					10f. Zip Code	CIDVII		10g	. Citizen of Wha	at Coun	ntry?
	Director	8338 RE	NELATION A	1ve	- 1	21	793			USA		
ath with the items 23a	Funeral	11. Marital Status	12. Was Decedent Eve		13 Was [Decedent of Hisp	anic Origin?	/ Specify V	es or No.	14 Race	Americ	can Indian, Black,
eath item	9	1 Never Married 2 M	arried Armed Forces?			, specify Cuban,				White,	etc.	
	띠	3 Widowed 4 Div	1 Yes 2	No	1 🗆 v	es 2 No	specify:			Specify:	211	ck
21215-0036 Id be filed within 72 hours afte Mental Hygiene. aarked other than "natural", event, the Medical Examiner	1	15. Decedent's Education (Spe	or Dates:	ted) 16a De		Usual Decupation		of work do	no I1	6b. Kind of Bus		
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C E E E	Bec	Δ.	GATES				RYSTA			MOSON		
Z. 2 4 4 5 1		19a. Informant's Name/Relations		19h	Mailing A	ddress (Street	and sumbor	or Pural Pa			Ctata	Tin Code)
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e, M 1 and 2 Health item 2	- 1	20a. Method of Disposition	<i>p</i> -0/1			n (Name of ceme		Date		20c. Location - 0		
Ore of H		1 Burial 2 Cremation	3 Removal from State	cremator		- l \	- 1				-	•
Pag ment tant:		4 Donation 5 Other Sp		FAIRVE	W (t	M.	\Q	i. 20,	2011 t	regerich	1	MD
Baltimore, permit. Pages 1 a Department of He Important: If ite injury or other tr		21. Signature of Funeral Service			22. Nam	place) PM ne and Address of	of Facility	ARY (. ROL	LUND M	iN.	100MG
		May 2. Roll			110 V	4537 500	unt ST	Tho.	06214	, mo	217	05
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/Medical Examiner		Immediate Cause (Final disease	a Sudden Unex	nlaine	i Dea	th In C	hi 1dha	12) boo	mrc)			Death
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		Sequentially list conditions,	b									
	ine.	if any, leading to immediate cause. Enter underlying cause	Due to (or as a conseque	nce of):								
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CO == 50 m	S 2:	3b. Was decedent pregnant in th	e 23c. If yes, outcome of		Fetal	death 3	Ectopic pre	gnancy		23d. Date of de Month	elivery Da	ay Year
x 6	일	past 12 months?	4 Pregnant at time		=	(Specify)		g,				.,
Box 687 ne death certifice the attending I	Physiciar	1 Yes 2 V No 9 Unk	nown 9 Unknown		_ 54101	(
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VIS or A of A of A Direc	<u> </u>		not be 28e. Place of Injury -	At home, farm	, street, fa	actory, office build	lding, etc.	28f. Loc	cation (Stre	et and Number	or Rura	al Route Number, City
Division ospital or Attence hours after death noursal Director: y filled in by the	Certification	4 Homicide determ	mined (Specify) Resid	dence				Wall	cersv	ille,Md	eve. •	lation Ave
Hos 24 h Fun stely	_ 4	9a. Certifier 1 Certifying Ph	ysician: To the best of my kno	wledge, death	occurred	at the time, date	and place, a	and due to t	he cause(s) and manner a	s stated	1
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use an example of the certificate has been signed by the attending the completely filled in by the funeral director, page 2 should be detached for use an example of the certification of the	ğ °	ne) 2 Medical Exam	niner: Dn the basis of examinat and manner stated.	tion and/or inve	stigation,	in my opinion, de	leath occurre	d at the tim	e, date and	place, and due	to the	cause(s)
H 3 F 8	2	9b. Signature and title of certifier	and Harrier Stateu.	1		29c. License n	number		29	9d. Date signed	(Mont	h, Day, Year)
		6/1	1 1 >	4	7	O.C.M.	.E.			October 14,	2011	
	3	0. Name and address of person v	yho completed cause of death	(Item 23a)	(1						-
			ssistant Medical Exam		N. Balti	imore Street	. Baltimor	e, MD 2	1223			
Stat	e 3	1. Date filed (Month, Day, Year)	32, Registrar's Si			197		,= =				
Registra		OCT 17	2011 Brewn	P. A	ack							
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	State Registrar	/F' · · · · ·	<i>II</i>				Certifica	te of i	Death	10.5		. No.	UII	328
an	1. Decedent's Nam Damon		dle, Last) Ger	ber						M	te of Death onth ober	Day 12	2011	3. Time of De 6:00an
el er	4a. Facility Name ((If not institution	on, give str	reet and nur	mber)		4b. City,	, Town, o	r Location of De		Obel		unty of Dea	
•	Harmony		Assis	ted L	iving			Colum				Hov	ward	
	5. Social Security i		6. Sex † √ □ i	M 2□F	7. Age (In yr 87	s. <i>last birtho</i> Yr:	Months		If Under 24 H Hours M	in. (M	te of Birth onth, Day, Yo	ear)	9. Bir	thplace (State or Fountry)
	Usual Residence							L		Jul	y 25 1	L924_		unknov
L.	10a. State 10b. County MD Howard				10c. City, Town or Location Mt. Airy								10d. Inside City	
Director	llowaru									10g. Citizen of What Country?				
	10e. Street and Number 17435 Frederick Road				10f. Zip Code 21771					USA				
Funeral	11. Marital Status 12. Was Decedent			edent Ever in	Ever in U.S. 13. Was Decedent of Hispanic Origin? (St.									
by Fu	1 ☐ Never Married 2 ☐ Married			veX No	If Yes, specify Cuban, Mexican, Puerto No 1 □ Yes 2 □ YNo Specify:					etc.)		Black, Whit ec <i>ify:</i> wh		
	3 Widowed	4 ☐ Divorced		Year or Da	ates:	16a D	ecedent's Usu				16		of Business	
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Be	17. Father's Name (First, Middle, Last)					18. Mother's Nam unkn					, Middle, Ma	iden Suri	name)	
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	Christin								phia Rd					
	20a. Method of Dis					. Place of D	isposition (Na crematory or c	me of other place	ce)	Date	20	c. Location	on - City or	Town, State
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygien® 0.1 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First: Middle, Last) 2. Date of Death 3. Time of Death Physician/ 925 WESSIE (TLAZER Chobes Medical OII 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death MORNINGSIDE HOUSE ASSISTED LIVING ELLICOTT CITY HOWARD Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 2/29/1919 056-05-7971 1 □ M 2 🖫 F 91 Months Hours Min. Country) Director NY Usual Residence of Decedent 10a. State 10b. County Examiner must be notified at 10c. City. Town or Location Director 10d. Inside City Limits MD HOWARD ELLICOTT CITY 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5330 DORSEY HALL DRIVE 21042 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 NNo If Yes, Give 1 ☐ Yes 2 🕱 No Specify. 3 Widowed 4 ☐ Divorced Specify WHITE Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) the EXECUTIVE SECRETARY MANUFACTURING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ PHILLIP BERNFELD PHILIP SARAH LEVINE 19a. Informant's Name/Relationship (Type, Print) 19b William 2dd Crass and Numbrer er Burel Boule Number Sity of Twin Brig. State & Co. 21044 5330 DORSEY HALL DR; ELLICOTT CITY, MD 21042 permit. Page 1 and 2 sh Department of Health as Important: If item 27 is any injury or other trau ESTA GLAZER-SEMMEL /DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Permoval from State 4 ☐ Donation 5 ☐ Other (Specify) CARROLL CREMATION INC 10/14/2011 HAMPSTEAD, MD Funeral Service Licensee Signature 22. Name and Address of Facility SOL LEVINSON & BROS., INC 8900 REISTERSTOWN RD; BALTIMORE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician, RESPIRATORY disease or condition resulting in death) VEELS Medical Due to (or as a consequence of) Examiner ONGESTIVE Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) ALVUlan Cause (Disease or linjury that initiated events burial-tra resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical 068h the use as IF FEMALE: 23c. If yes, outcome of pregnancy
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1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death signed by the at d be detached fo 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 No 3 Probably 4 Unknown After this certificate has been si funeral director, page 2 should 24b. Were autopsy findings available 24a. Was an autopsy performed?
Yes 2 No prior to completion of cause of death? 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 45 sole Line မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specific 28a. Date of injury 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending injury work? Accident Investigation Μ 1 Yes 2 No completed filled in by the 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate h

Division of Vital Records,

law requires that the death certificate be P.O. Box 68760

> State Registrar

28a-f show

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"natural", or

Page 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

and Mental Hygiene. is marked other than

Baltimore, Maryland 21215-0036

with the Maryland

29b. Signature and title

on who completed cause of death (Item 23a) (Type, Print

gc. License number

856

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2.011 0545 Joyce R. Jones Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Memorial ALBOT ASTON . Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 🗆 M 2 🔯 F Hours July 5, 1940 Maryland 215-38-0482 Director 71 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at **Funeral Director** 1 Yes 2 No Caroline MD Preston 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? items 23a 21655 IISA 21269 Doverbridge Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. "natural", or þ 1 Never Married 2 Married 1 Yes : 2 XNo permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once. Elementary/Seconday (0-12) College (1-4 or 5+) housewife own home unk unk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ William Retallack Katie Marshall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Allen Wingate/son 27794 Villa Road Easton, MD 21601 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 Q Other (Specify) 21. Signa use of Funeral ervice Licensee State Anatomy Board 655 W. Baltimore Street Director timore. MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Newic Medical Due to (or as a consequence of) **Examiner** onno 9 Sequentially list conditions, rany, reading to infinediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Examin Hospital or Attending Physician: The law requires that the death certificate be executed Athors after death.

Funeral Director. After this certificate has been signed by the attending physician and eted filled in by the funeral director, page 2 should be detached for use as the burta-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Hinknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an performed? Yes 2 No death? 2 🗌 No Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital 2. No Other: ၉ 1 🗌 Yes 1 Depatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 24 hours a Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the l within 2 To the l 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature

State Registrar and title of certifier

1. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

DO05311

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Mont Physician/ Baby Boy Khandan Medical 4a. Facility Name (if not institution, give street and number) Examiner Town, or Location of Death 4c. County of Death 10 It Mare 5. Social Security Number 6. Sex Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 😾 M 2 🗆 F Months 2^{Min.} Oct 7, 2011 Hours 4 Maryland Director infant Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits with the Maryland Director 1 🗆 Yes 2 😾 No VA Springfield 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 7717 White Willow Court 22153 IISA within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. o, 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 💢 No Specify: iranian Specify "natural" 3 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) th and Mental Hygiene.
It is marked other than traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) infant infant infant infant Be iled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be fill tment of Health and Mental tant: If item 27 is marked o 2 Jvan Zebari Harez Khandan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) The Johns Hopkins Hospital 600 N. Wolfe Street Baltimore, MD other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ott cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 \ Other (Specify) in state 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street pectar timore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, wheart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Priysician/ ventria disease or condition resulting in death) Medical Due to (or as a consequence Examiner 0 Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Die to for as a consequence of the Hospital or Attending Physician; The law requires that the death certificate be executed as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) ttending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death signed by the Id be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? death? After this certificate 2 🗌 No Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 **X** No Other: မှ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation the within 24 hours after deatl To the Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, pleted filled in by 4 - Homicide determined Medical 29a. Certifiei 1 🔏 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b Signature and title of certif 29d. Date signed (Month, Day, Year) 29c. License numbe

Registrar

State

gietrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ner

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Robert Lee Lawrence 13:16 P M October 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton PG Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1**X** M 2 □ F Months Hours Min 02/24/1948 266-72-0432 63 **Director** Florida Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD PG Temple Hills 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 3602 Portal Avenue 20748 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ☐ Yes 2X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify. 3 Divorced Black Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) 2 years Phlebotomist Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Malachi Lawrence Carrie Bell Anthony 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra Mary E. Lawrence (Wife) 3602 Portal Avenue; Temple Hills, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Resurrection Cemetery 10/21/2011 4 Donation 5 Other (Specify) Clinton, Maryland ure of Funeral Service Licenses 22. Name and Address of Facility Freeman Funeral Services 4594 Beech Road; Temple Hills, MD art 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ TULMONARY RUSLS disease or condition Due to (or as a consequence of) Medical resulting in death) Examiner SPIRATORY Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events that the death certificate be executed VCSPHALDPATHY burial-transit PERTENSIVE Due to (or as a consequence of) resulting in death) Last physician Physician/Medical POX1A Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Pregnant at time of death Month Day Year 2 No the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 s autopsy performed 2 No 1 🗌 Yes Yes 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

within 24 hours a

DHMH 17 Rev 7/2009

State Registrar Signature

me and address of person who completed days

of death (Item 23a) (Type, Print)

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Contifying Nursu Fractioner: To the best of my knowledge, death analysed at the time date and place, and due to the causale) and manner as stated

URRATTS

ROAD

CLINTON,

			Please Type or Print in Bla 1 - For State Registrar amend items 19a, b, 20a c, 22							ible.	32899
	Physici		1. Decedent's Name (First, Middle, Last)			eath	2. D	ate of Dear	th Day	Year	3. Time of Death
parint,	Medi Exami				4b. City, Town, or Baltin		of Death	7/	22 / 2 4c. County	of Death	711031
	Funeral Director		5. Social Security Number 218−76−9018 6. Sex 1 □ M 2 ▼ F 94	oirthday) Yrs.	If Under 1 Year Months Days	If Under Hours		ate of Birth fonth Day, n 15,	Year) 1917	9. Birthplac Country Mary 1	e (State or Foreign and
	ryland I-f show ied at	ctor	Usual Residence of Decedent 10a. State 10b. County 10c. City, To							10d.	Inside City Limits
	ith the Ma 3a or 28a it be notif	Funeral Director	MD 100. Street and Number 4012 Alto Road	Balt:	Imore 10f. Zip Code	1016			10g. Citizen of V		1
036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 Never Married 2 Married 1 Yes 2 No	lf lf	/as Decedent of His Yes, specify Cuban ☐ Yes 2 🛣 No	, Mexican	gin? (Specify Ye , Puerto Rican,	es or No- etc.)	14. Race	SA e - American k, White, etc. blac	
21215-0036	l within 72 hour /giene. ner than "natu t, the Medical	Be Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) unk 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) unk	(Give k	ent's Usual Occupa ind of work done du NOT use retired)			unk	16b. Kind of Bu	siness Indus	try unk
Maryland	should be filed n and Mental Hy 7 is marked ott raumatic even	To B			unk	18. Mothe	er's Name (First	, Middle, N	Maiden Surname)	unk
	and 2 shou Health and Pm 27 is n ther traum	1	Ardie Snaw/Dept on Aging	201	Z ^{idr} Asl Etreet R E. Baltin	d Numbe	r or Rural Rout Street	Balt:	City or Town, Siimore, N	tate, Zip C 2 d ID 21 2	216 202
Baltimore,	t. Page 1 attent of H rtant: If ite		1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) in State Mt. Z	tery, crem ion (ition (Name of atory or other place Cemetery		Date 10–31–	11	20c. Location -	me Mo	
Bal	permit Depar Impor any in	1	21. Signature Funeral Service Livensee tonal 1 Wade Wade	<u> Ba</u>		MD -	$\frac{21201}{21201}$	<u> 21217</u>	638 N.	PA re St Gilmo	reet or St.
4	Ph. sician/ Medical Examiner		23a. Part L Enter the disease, or complications that caused the death. Do shock or heart failure. List only one cause in each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence)	clo	the mode of dying,					Int	proximate rerval Between set and Death
	executed an and ial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events.	s oi).							
09289			resulting in death) Last Due to (or as a consequence	of):							
. Box 68	The law requires that the death certificate be attending physici ate has been signed by the attending physici page 2 should be detached for use as the but	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months 1 ☐ Live Birth 2 ☐ Fetal dea 1 ☐ Pregnant at time of death 9 ☐ Unknown		Ectopic pregnancy Other (specify)				23d. Date Mor	e of delivery	y Year
ds, P.O	requires that the de been signed by the should be detached	ρ	Part II. Other significant conditions contributing to death but not resulting	in the un	derlying cause give	n in Part I.	. 2		pacco use contri		ause of death?
Record	The law req	Completed				77		4a. Was ar autops perforr	ngad? p	rior to comple eath?	findings available etion of cause of
/ital	Attending Physician: The sr death. ector: After this certificate by the funeral director, pag		25. Was case referred to medical examiner? Hospital:		Other	1	h (Check only o	ne)			
of \	ing Phy		I inpatient 2 in ER/C	Time of injury	28c. Injury a				ence 6 Other w injury occurre		
Division of Vital Records,	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Certificate:	2 Accident 3 Suicide 4 Homicide Investigation Could not be determined Could not be determined 28e. Place of Injury - At home, for building, etc. (Specify)	arm, stree	M 1 🗆 Y	es 2 🗌	28f. Lo	ocation (Str ty or Town	reet and Number , State)	r or Rural Rou	ute Number,
	To the Hospital or within 24 hours afte To the Funeral Director Completed filled in I	Medical	29a. Certifier (Check only one) 1	or investic	ation, in my opinion.	, death occ	curred at the tim	ne, date and	diplace and due	to the cause(s	s) and manner stated.
	To the within 2 To the comple		29b. Signature and title of certifier M.D		29c. License r		-05		9d. Date signed		
_			30. Name and address of person who completed cause of death (Item 23a) LIAOATALL 821N	(Type, Pri	iteust	. 8	balti	mne	MO	2/	201
	Stat Registra	G	31. Date filed (Month, Day, Year) 32. Registrar's Signature 0CT 1 7 2011	1	arkel						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #87 Per AN BD 11/07/2011 JH State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Charles Murphy Medical Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Plato Sept Bi27, 1947 July 24 Year 1948 If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign 1 🔀 M 2 🗆 F Months Days Director 211-38-7025 63 Pennsylvania Usual Residence of Decedent 23a or 28a-f shov th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo MD Charles Bryans Road 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 2144 Boxwood Circle 20616 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 X Yes 2 No If Yes. Give Black White etc þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white Completed 3 Widowed 4 Divorced Specify: 165-68 Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 AT&T project manager Be ... yid!.
... ege 1 and 2 should be file.
... epartment of Health and Mental Hy
Important; If item 27 is marany injury or other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Joseph Murphy Ruth Barbara Rietscha 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 2144 Boxwood Circle Bryans Road, MD 20616 Margaret L. Murphy/spouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) Signature of Funeral Service Ronald Stare and Address of Facility oard 655 W. Baltimore Street MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac r heart failure. List only one cause on each line. nterval Between Immediate Causa IFinal Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** vere Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a con To the Hospital or Attending Physician; The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-tran that initiated events resulting in death) Last Due to Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an within 24 hours after death.

To the Funeral Director, After this certificate has completed filled in by the funeral director, page 2: prior to completion of cause of death? autopsy performe 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 21 No Other: မ 1 Inpatient 2 -ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work?
1 \(\sum \) Yes 2 \(\sum \) No 5 Pending injury Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29c. License numbe 2011 0 Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 19a per inf/sa,g920,10/24/2011dib 1 - For State Registrar Certificate of Death Reg. No-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Lindsa K. MacDonald 12:30 PM September 26, 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2603 Felter Lane Bowie Prince George's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 🗓 F Yrs. 62 July 6, Director 1949 236-78-6003 West Virginia Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov ral", or items 23a or 28a-f shov Examiner must be notified at MD Prince George's 1 ☐ Yes 2√∑ No Director Bowie 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2603 Felter Lane by Funeral 20715 Pages 1 and 2 should be filed within 72 hours after death in not Health and Mental Hygiene. USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 XX No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐Yes 2X No Specify Specify: white 3 Widowed 4 Divorced 'natural", Completed th and Mental Hygiene.
7 Is marked other than "natur traumatic event, its Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 teacher education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Lindsay Johnson Virginia Lee Williams ျှ 19a. Informant's Name/Relationship (Type. Print)

Tracy MacDonald/epouse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 2603 Felter Lane Bowie, MD 20715 other t Department of Heal Important: If item 2 any Injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) License 22. Name and Address of Facility Ronald State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Wad Pat 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a Was an autopsy performed? Yes 2 No 2 NO 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 □**X**(Vo 1 Yes ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: Natural 2 Accident 5 Pending investigation

Box 68760, o. ۵. of Vital Records, Division

the Maryland

with

Baltimore, Maryland 21215-0036

permit.

death certificate be executed and physician as the burial-t attending p for use as ed by the a signed by t I be detach has this certificate the Hospital or Attending Physician: After after death. in by the

29a. Certifier (Check only one)

3 ☐ Suicide

4 ☐ Homicide

and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

6 ☐ Could not be

29c. License number

29d. Date signed (Month, Day, Year)

and address of person who completed cause of death (Item 23a) (Type, Print)

100

31. Date filed (Month, Day, Year)

32.

Drano N

within 24 hours a

To the Funeral filled

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Medical

State Registrar

Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. & 19a Per ANA BD G920 10/27/20 The JH State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2011 Physician/ Montl 5, 5:44 PM M Joseph King Marine October Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Towson Gilchrist Hospice Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Days Months Hours Min. (Month, Day, Year) Country **Director** 99 436-07-9335 1 X M 2 □ F Yrs 1912 Usual Residence of Decedent 13 Louisana Sept "natural", or items 23a or 28a-f show edical Examiner must be notified at . Page 1 and 2 should be filed within 72 hours after death with the Maryland timent of Health and Mental Hygiene. Tant: If item 27 is marked other than "natural", or items 23a or 28a-f shoi jury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Baltimore MD 10e. Street and Number 3855 10f. Zip Code 10g. Citizen of What Country? #242 Funeral USA #205 21211 Greenspring Avenue 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 black 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced 41-45 Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) state of New York chaffuer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Alice Nelder Joseph Marine 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9400 Wordsworth Way #205 Owings Mills, MD 211117 Joanne Joseph/daughter o Ann Joseph/neice 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place. ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department Important: If any injury or 4 ☐ Donation 5 🗓 Other (Specify) in state Sign ture of Funeral Solvice Licensee Ronald S. Wade State Anatomy Board 655 W. Baltimore Street 222 21201 MD 23a. Pat 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) حار Onset and Death Physician/ want (Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and I for use as the burial-transit Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Year Pregnant at time of death 5 Other (specify) signed by the at id be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, the Hospital or Attending Physician: The law requires 1 Yes No 3 🗆 Probably 4 🗆 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an Jas autopsy performet 2 Director: After this certificate I 1 🗆 Yes 2 🗆 No completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2/1 No Hospital Other: 1 Yes မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending after death. ☐ Accident ☐ Suicide М 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 29a. Certifier -Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the only on Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature a td title of certifier 29c. License number 29d. Date signed (Month, Day, Year) TUSE 5 2011 ss of person who completed cause of death (Item 23a) (Type, Print) Amon TOUSON M, 6701 IV. barres. 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 6 Irene Mason 2011 10:42 A Medical Examiner 4a. Facility Name (if not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 😿 F Days Washington, DC 75 Hours Director 578-48-8165 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits DC Washington 1 X Yes 2 No 10e, Street and Number ō 10f. Zip Code ral", or items 23a or Examiner must be 10g. Citizen of What Country? Funeral 5532 Jay Street, N.E. 20019 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2X No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2XXNo Specify: "natural", Completed 3 X Widowed 4 □ Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12th Domestic Self Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 and 2 should be Health and Ments unk Mary E. Mason 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Janice E. Mason (Grand-daughter) 5532 Jay Street, N.E.; WDC 20019 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Chesapeake Crematory 10/14/2011 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Freeman Funeral Services 4594 Beech ROad; Temple Hills, MD Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Interval Between Immediate Cause (Final Onset and Death ₽nysician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Pregnant at time of death Day Year g Unknown 9 Unknown Other significant conditions contributing to death but not resulting in the underlying pause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed? Unnic Rona certificate 2 🔲 No 1 Yes To Be 25. Was case referred to nedical 26. Place of Death (Check only one) examiner? Hospital: in 24 hours after ceau... the Funeral Director: After this ce noleted filled in by the funeral dire 2 No Other: 1 Anpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 1 Natural 5 Pending injury ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29c. License number Name and add who completed cause of death (Item 23a) (Type, Print) 4701

State Registrar 31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 4:15 Physician/ 120 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner n/a Baltimore Elizabeth's Nursing Home If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Ye May 27 9. Birthplace (State or Foreign **Funeral** 1 M 2 D F Months England 89 220-52-2659 Director May Usual Residence of Decedent 28a-f show 10d. Inside City Limits ral", or items 23a or 28a-f shor Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location within 72 hours after death with the Maryland Director 1 ☐ Yes 2 🖾 No Halethorpe MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21227 Funeral 917 Wilton Drive United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12 Was Decedent Ever in U.S. 11. Marital Status Armed Forces? þ 1 Never Married 2 Married "natural", or Specify: White Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 Divorced 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Health Care Maintenance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Health and Mental Hi Important: If item 27 is marked ott any injury or other traumatic even မ Mae Balderstone Alfred P. Marriott 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 917 Wilton Drive Halethorpe, MD 21227 19a. Informant's Name/Relationship (Type, Print) Marie Marriott - Wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place)
Loudon Park Cemetery

Oct.12,2011 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 22. Name and Address of Facility Ambrose Funeral Home, Inc. 21. Signatu e of Fluneral Service Lip reee 1328 Sulphur Spring Road Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ent disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner 20010 1 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events Examine Due to (or as a consequence of) ohysician and the burial-transit To the Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Pregnant at time of death signed by the a d be detached f g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 1 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 has 25. Was case referred to medical 26. Place of Death (Check only one) Be director, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral or 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 5 Pending 1 Natural 2 No Investigation ☐ Accident ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) CRUC 1017/11 R111615 Avenue Benson 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3320 10 altomor コーマョフ Golds borough 31. Date filed (Month, Day, Year)

OCT 1 7 2011 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ OCTOBER 2011 7:45 PM PESCATORE FRANK EUGENE Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK . Social Security Number 8. Date of Birth (Month, Day, Yea Aug. 2 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 X M 2 | F Months Days Hours Min. Maryland Director 58 215-48-7422 Aug. 1953 Usual Residence of Decedent show r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 XYes 2 □ No Carrol] Maryland Taneytown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral within 72 hours after death with 14 Commerce St. 21787 U.S.A. 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 h and Menta! Hygiene. 7 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) 12 master technician automotive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic conce. Frank Pescatore traumatic Teresa Yohn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine Pescatore/ wife 14 Commerce St. Taneytown, MD 21787 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Mem. Gard. 10/15/2011 Frederick, MD 21. Sign turp of Fundral Service Licen 22. Name and Address of Facility Hartzler Funeral Home 404 S. Main St. Woodsboro, MD 21798 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph, sician/ pheumohia disease or condition Medical resulting in death) Due to (or as a conseque ce of): **Examiner** Sequentially list conditions, ner cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of: Exami bleuval the Hospital or Attending Physician: The law requires that the death certificate be executed and -tran that initiated events resulting in death) Last Due to or as a consequence of): physician s the burial burial Physician/Medical P.O. Box 68760 attending p yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

The string of death 5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, bomoreanic cancel Completed 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 s has autopsy performed? 1 ☐ Yes 2 ☐ No completed filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 욘 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending injury To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No Accident Suicide Investigation M 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Acertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 72977 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Marius Nefliu 400 W. Seventh St. MD 21701 Frederick

State

Registrar

31. Date filed (Month, Day, Year)

7 2011

backs

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

inda Ryan		State of Maryland / Departme 1- For State Certificate	nt of Health and Mental te of Death		2011	32906
Physic dical Exam		Decedent's Name (First, Middle,Last)		2. Date of Death Month Cotober 13,	Day Year	3. Time of Death 2012 hrs
		4a. Facility Name (if not institution, give street and number) 404 S. Calhoun Street	4b. City, Town, or Location of De Baltimore		4c. County of Death	<u> </u>
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho		8. Date of Birth	Foreig	thplace (State or gn MD untry)
nd show any ice.		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Bal	Location timore			10d. Inside City Limits 1 X Yes 2 No
rith the Maryland 1232 or 282-f show : notified at once.	Director	10e. Street and Number 404 S. Calhoun Street	10f. Zip Code 21 22 3	10g	Citizen of What Cou USA	ntry?
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland near of Health and Mental Hygers than the Maryland in the filed 27 is marked other than "natural", or items 23s or 23s fish or other traumatic event, the Medical Examiner must be notified at once	by Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	3 Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue) 1 Yes 2 No specify:	rto Rican, etc.)	14. Race - Ameri White, etc. B1 a	ican Indian, Black,
5-0036 led within 72 hours Hygiene. other than "natur	Completed I	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Hol	cedent's Usual Occupation (Give kind of ring most of working life. DO NOT use r $1y$ $Farm$ $Poultry$	retired)	Food Ser	
ID 21215-0036 : should be filed within 77 and Mental Hygiene. 77 is marked other than natic event, the Medical	Be	Alfred Davis	Patri	me (First, Middle, Ma	,	
MD 21 nd 2 should alth and Me m 27 is ma	To	Patricia Ryan 33	Mailing Address (Street and Number of B07 Lyndale Ave	nue Balt	O MD 212	13
Baltimore, MD permit. Pages I and 2 sh Department of Health and Important: If item 27 is injury or other traumat		4 Donation 5 Other Specify: Cremation 3 Removal from State crematory Arden	Disposition (Name of cemetery, or other place)	1-10-11	20c. Location - City or Baltimore Hanover	→ MD
		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Ph 2431 E Oliver			
Physician /Modicul Examiner		and the second s	nter the mode of dying, such as cardiac cation cation		t, shock, or heart	Approximate Interval Between Onset and Death
	Ē	or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Due to (or as a consequence of):				
cuted und transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last				
e exe	dical	X UNPENDED I as noted,	23a,27,28a-f,per	me 20a-b p	per fh	
Box 68760, e death certificate but the attending physical for use as the but	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 V Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Pregnant at time of death 5	Fetal death 3 Ectopic preg Other (Specify)	nancy	23d. Date of delivery Month E	/ Day Year
s, P.O. Boires that the designed by the	ē	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.		acco use contribute to	
p regr	Completed			24a. Was an autopsy performe	prior to death?	topsy findings available completion of cause of
Vital Recol hysician: The law this certificate has I	o Be C	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpi	26 Place of Death (Checatient 3 DOA Other Nurs		esidence 6 🗸 Other	
on of ending Phath. or: After the funeral	-1	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time 1 Natural 5 Pending Fd. 10. 12. 11 Fd. 10. 12. 11	28c. Injury at Work? 1 Yes 2 X No	28d. Describe how		
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certif completely filled in by the funeral director,	Certification:	3 Suicide 6 X Could not be determined (Specify) Tesider	, street, factory, office building, etc.	28f. Location (Street or Town, State	eet and Number or Ru te) 404 S. C re, Md. 21	ral Route Number, City alhoun St. 223
To the Hosvithin 24 h	Medical (29a. Certifier 1 CertifyIng Physician: To the best of my knowledge, death one) 2 Medical Examiner: On the basis of examination and/or inversity and manner stated.				
	ž	29b Signature and title of certifier Pamela Kouthall, MI	29c License number O.C.M.E.		29d. Date signed (Mor October 14, 2011	
		30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner	900 W. Baltimore Street, Bal	timore, MD 212	223	
St Regist	ate rar	31. Date filed (Month, Day Year) 32. Registrar's Signature	V.)			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. ammend #oper ANA BD G920 10/31/2011 JH State of Maryland / Department of Health and Mental Hygiens | | Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2:45 PM M September 28, 2011 Lavonne Reaver /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Rockville Shady Grove Center

5. Social Security Number | 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 1930 (Month, Day, Year) Mar 7, 2930 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, **Funeral** Days 1 □ M 2 🖫 F Yrs Iowa Director 215-26-8193 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State the Maryland 10b. County a or 28a-f show be notified at show 1 ☐ Yes 2 No Tanevtown Director Carrol1 MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with USA Items 23a of Iner must by 21787 1911 Trevanion Road by Funeral Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene.
Init: If team 27 is marked other than "natural", or Items 23, mix; If item 27 is marked other than "natural", or Items 13, or other traunatic event, the Medical Examiner must iny or other traunatic event, the Medical Examiner must 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: white 1 ☐ Yes 21☑ No Baltimore, Maryland 21215-0036 3 ☐ Widowed 4 X Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) apparel seamstress 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Irene Mae Klinefelter Walter Leroy Masemore ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1913 Southview Court New Freedom, PA 17349 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau once. Beverly Davies/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Eune | Service Licen | e Ronal | S. Wade 21. Signature rirector Baltimore, MD 21201 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or healt-failure. List only one cause on each line. Immediate Cause (Final 2 months **Physician** disease or condition resulting in death) failure to thrive /Medical Due to (or as a consequence of) Examiner 2 years lung cancer Sequentially list conditions, if any, leading to immediate cause. Enter thirderlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and Due to (or as a consequence of) Box 68760. physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 menths? 1 ☐ Yes 2 🕱 No 4☐Pregnant at time of death 5 Other (specify) Division or Vital Records, P.O. a□Unknown 9 Unknowń ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à hypertension. COPD 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 2 ER/Outpatient 3 DOA ^oL 1 Inpatient 28a. Date of Injury (Month, Day Year) 28h Time of 28d. Describe how injury occurred 27. Manper of Death 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. ours after death.
neral Director:

filled in by the fu 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital o within 24 hours af To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check onli and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signerare and title of certifier October 5, 2011 D 28656

6) State

30. Tame and address of person who completed cause of death (Item 23a) (Type, Print) Ravi Passi MD 15245

Shady Grove Rd #130 Rockvlle, MD 20850

31. Date filed (Month, Day, Year)

OCT 1 7 2011

Registrar

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 12:18A M Bernice K. Rice October 8 2011 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Encore at Turf Valley Howard Ellicott City If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 12-17-1933 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 25 XF Yrs. Maryland 77 215-28-5369 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examiner must be notified at 1 Yes 2 No Director MD Howard Elkridge 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 5942 Montgomery Road 21075 Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 21 No Specify: White 3 XWidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Rice University 12 Domestic Engineer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last)
John
James Kaszak Be Helen Grochowski 19b. Mailing Address (Street and Number of Russ Poute Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) -Chatan, NJ 07928 Pages 1 and 2 ment of Health item 27 James Rice (son) 57 Chandler Road Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition permit. Pages Department of I Important: If its any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Atlantic Crematory 10-10-2011 Glen Burnie, MD 4 □ Dopation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gary L. Kaufman Funeral Home, Inc. 7250 Washington Blvd. Elkridge, MD 21075 23a. Part1. End the disease, or complications that as sed to shock, or eart failure. List only one cause on each line sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition monetro **Physician** Metastan resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ing physician and as the burial-transit certificate be executed Due to (or as a consequence of) Box 68760 attending physician Physiclan/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetel death
4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) P.O. I detached 9 🗆 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? esternon 24a. Was an has autonsy performed? Meumetoid 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: ursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 Yes 2 No 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 2 Accident Injury 5 Pending 1 Yes 2 No To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

State

DO053150

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Speph Mn 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Senhato Rd

067 10th

peste 9650 5 hour mole

2011

32. Registrar's Signature

Registrar

à

Medical

4 Homicide

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Year SMKTH RICHARD ALEXANDER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** JASHINGTON LAST WASHINGTON AGERSTOWN 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country)
 D. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days Hours Min. 1 M 2 -Months 62 214-48-4581 Director 11, Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10b. County must be notified at Director MD. WASHINGTON HAGERSTOWN 1 🖊 Yes 2 🗌 No 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number ò 23a Funeral WASHINGTON ST. 21 USA TAST items 2 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Examiner Armed Forces? Black, White, etc. ō 2 1 Never Married 2 ☐ Married hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No If Yes Give Specify: Specify: BLACIC "natural" Completed 3 Widowed 4 Divorced Year or Dates. the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry PRANSPORTATION t of Health and Mental Hygiene. If item 27 is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) DRIVER YRS other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) SR. DAVIS ALICE RICHARDA, SMITH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FREDERICK MD ZITOI ALICE SMITH 251 WEST 5TH ST Page 1 and 2 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State permit. Page Department o Important: If MD. SMITHS BURE SMITHSBURG CREM. 10ct. 11,2011 4 Donation 5 Other (Specify) any injury 22. Name and Address of Facility GARY L. ROULUS FUN-HOME 21. Signature of Funeral Service Licensee Colle SOUTH ST' FKEDBRICK MD 21701 Som or. 110 WOST 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PERKALEMIA Physician/ disease or condition resulting in death) Medical Due to (or s a consequence of Examiner MPLIMUCE MEDICA Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) and I-transit Exami that initiated events resulting in death) Last Due to (or as a consequence of) -burialphysician the burial Physician/Medical The law requires that the death certificate be of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ atter in the past 12 months?
1 ☐ Yes 2 ☐ No ρ Month Day Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 2 No 3 Probably Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy has perform certificate 1 Yes 2 🗌 No or Attending Physician; director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ည this 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred Natural injury 5 Pending Division within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 🗌 No Investigation Accident 3 Suicide
4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29d. Date signed (Month, Day, Year) of certifie 556 MO d address of person who completed cause of death (Item 23a) (Type, Print) 140 THOMAS JUHNSON DRIVE, FREDERICK, MD WILLIAM H . JUHNSON MD 31. Date filed (Month, Day, Year) - 32. Projetrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Southers Physician/ Addie Month. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Battimore **Examiner** Gilchnis HOSPICE OWSON If Unde Year If Under 24 Hrs. Social Security Number Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Min (Month, Day, Year) **Director** 1 🗌 M 2 🗗 North Cardin 10d. Inside City Limits 10b. County 10c. City. Town or Location items 23a or 28a-f sho her must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland **Funeral Director** Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? 21217 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black Black. ō 1 Yes 2 No If Yes, Give Year or Dates. 1 Neyer Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 ₩idowed 4 Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working iife. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me Elementary econdary (0-12) College (1-4 or 5+) COOK Be 17. Father's Name (First, Middle, Mother's Name (First, Middle, Maiden Surname) ပ Velle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Southers 20b. Place of Disposition (Name of cemetery, crematory or other)

Bulfimore Nation 20a. Method of Disposition Department of H Important: If ite any injury or oth 1 Burial 2 Cremation 3 Removal from State Maryland time re 4 Donation 5 Other (Specify) uneral 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arre Approximate shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Physician/ ore BROVASCULAR ACCIDONI disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) sician and burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the buria To Be Completed by Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months Pregnant at time of death g Unknown Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?] 1 Yes 2 No 3 Probably 4 Onknown DIABOTES MELLITUS 24a. Was an Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy performed CRONARY Hospital or Attending Physician: 25. Was case referred to me 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 2 **N**O 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred 5 Pending Natural 2 No within 24 hours after death. To the Funeral Director: A Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one) 29b. Signature and title of certifie 29d. Date signed (Month,

5 5

State Registrar dress of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 26, per phy g920 10-17-11 sm State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2 3. Time of Death Physician/ 2011 Year October Danny Stevens 12:17 P M [3] Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death St. Joseph's Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month), Days | Hours | Min. | Nov. 18, 1955 5. Social Security Number 7. Age (In vrs. last birthdav) **Funeral** 9. Birthplace (State or Foreign 1 🙀 M 2 🗆 F Country Maryland 0/67/2011 218-82-4755 Director 55 Yrs. Usual Residence of Decedent items 23a or 28a-f shov ed other than 'natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits Baltimore Towson 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1 Lyric Court USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? 1 2 Yes 2 2 No Black, White, etc. ģ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: White 3 Widowed 4 Divorced Completed reven 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) e filed within Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Construction Roofing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ イススグ Sam Stevens permit. Page 1 and 2 should e Department of Health and Ment Important: If item 27 is mar e any injury or other traumatir ence. Fatima Guv 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sonny Stevens-Brother 3338 Acton Road, Parkville MD 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 [XBurial 2 Cremation 3 Removal from State Western Cemetery Oct.13,2011 Baltimore Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Am rose Funeral Home of Lansdowne 21. Signature of Funeral Service Licenses 2719 Hammonds Ferry Road Lansdowne Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Respirator disease or condition Medical resulting in death) Due to (o as a consequence o **Examiner** equantially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine o (or as a consequence of): requires that the death certificate be executed sphagia attending physician and for use as the burial-tran Due to (or as a conseduence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ signed by the atter in the past 12 months? Pregnant at time of death Month Day Year 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death. Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 ☐ No Hospital Other: မ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Chaked 1 Natural
2 Accident
3 Suicide
4 Homicide (Month, Day, Year) 5 Pending 10/06/2011 0039A 1 Tes 2 **N**No Investigation Director: on Hot Dog 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) / Lyric Towson MD 21204 determined within 24 hours a To the Funeral I Home MU Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature 29c. License number SOL address of person who completed cause of death (item 23a) (Type. HINGT. LU irimb 32. Registrar's Signature th, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Octobe 11:33 AM Medical 2011 Facility Name (if not institution, give street and number) **Examiner** City, Town, or Location of Death 4c. County of Death University Ballimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Country 1 □ M 2 🖳 F Months Min Feb. 6, Hours 216-76-2175 1962 Director 49 Usual Residence of Decedent shov 10a. State 10b. County iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MD 1 Yes 2 1 No Baltimore Halethorpe 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 320 Forth Avenue 21227 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 72 hours after 1 Yes 2 No Specify. White "natural", Completed 3 Widowed 4 Divorced Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed, I Hygiene. within 7 Elementary/Seconday (0-12) College (1-4 or 5+) the Caregiver Health Care Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ္ James Swinney Ola Mae Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Amy Walter-Daughter Bloomsbury Avenue Catonsville Maryland 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Oct.15 2011 Atlantic Crematory 4 Donation 5 Other (Specify) Glen Burnie Maryland 22. Name and Address of Facility Ambrose Funeral Home of Lansdowne Signature of Funeral Service Licenses 2719 Hammonds Ferry Road Lansdowne Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ Gram Negative disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Klebsiella Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy Month Year Pregnant at time of death 5 Other (specify) Day 1 ☐ Yes 2 g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 XYes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an after death. Director; After this certificate has it autopsy performed Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No 1 Yes Other: 읻 1 Minpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending Accident 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signatuj d title of 1952600108

State Registrar David

Date filed (Month,

Ballimar, MD

S. Fremont Ave

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Yocker

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** M ora 201 Octobe /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, Examiner Johns Hopkins Bayview Medical Center **Baltimore** . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🟋 F Months Days 62 213-54-4947 Director MAY12,1949 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits or 28a-f show at Examiner must be notified Directo MD. BALTIMORE DUNDALK 1 Yes 2 XNo 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. 21222 U.S.A. 7004 RAILWAY AVENUE items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 24 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married ō 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify þ Specify. WHITE 3 Widowed 4 Divorced Year or Dates "natural", Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) than College (1-4 or 5+) and Mental Hygiene. is marked other than OWN HOME HOME MAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be EMMA KEIPER THOMAS MARUSIODIS ည 19a. Informant's Name/Relationship (Type. PrintHUSBAND 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health as Important: If item 27 is any injury or other trau-once. 7004 RAILWAY AVENUE BALTIMORE, MD.21222 DENNIS M. SCHNITKER 20a. Method of Disposition
1 ☐ Burial 2 ⚠ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State OCTOBER 4 Donation 5 Other (Specify) 18,2011 BALTIMORE, MARYLAND BAYVIEW CREMATORY 21. Signature of Funeral Sen 22. Name and Address of Facility ACZOROWSKI FUNERAL HOME, PA M00933 MD 21222 1201 DUNDALK AVENUE BALTIMORE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) The law requires that the death certificate be executed physician and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) signed by the att 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 1 ☐ Yes 2 X No 2X ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence ည 6 Other (Specify) this 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred s after death. I Director: After the Certification: 1 ✓ Natural 5 Pending investigation (Month, Day Year) Injury 1 TYes 2 🗌 No 2 Accident the 3 ☐ Suicide Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide City or Town, State) To the Hospital or within 24 hours at To the Funeral D completely filled it 29a, Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature 29d. Date signed (Month, Day, Year) D0069915 octobec no completed cause of death (Item 23a) (Type, Print) Tabriel 4940 Eastern Avenue, Baltimore, MD, 21224 OCT 1 7 2011 31. Date filed (Month State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** 4, Douglas H. Taylor October 0 2011 8:49 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 14908 Spring Meadows Drive Germantown Montgomery Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Hours Months 1 € M 2 □ F Days Director 1961 578-64-6488 Apr 4, Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State 28a-f show 7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the incident Examinar must be motified at 1 ☐ Yes 2√ No Director MDMontgomery Germantown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 14908 Spring Meadows Drive 20874 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, unk Armed Forces' Black White etc. 72 hours after 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 No unk Baftimore, Maryland 21215-0036 1 ☐ Yes 2 No white Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry unk Elementary/Secondary (0-12) College (1-4or 5+) unk unk Health and Mental Hygiem 27 Is marked other 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) unk Be pe 2 unk 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Montgomery County Police Department other t permit. Pages 1 and Department of Heal Important: If item 2 any Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) in state 21. Signature of Funeral Service Licensee Ronald S. Wade 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Approximate Interval Between Onset and Death 23a. Partt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate (Final disease or condition resulting in death) **Physician** ue to (or as a cons. quence of): 1/Medical [{]Examiner Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 270410 Due to (or as a consequence of) Examine law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Box 68760. physician Physician/Medical the as attending I IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) signed by the a P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autopsy performed? 1 Yes 2 No the Hospital or Attending Physician: The certificate 1 ☐ Yes 2 No Division of Vital this certific al director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပို After this funeral o 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) To the I within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific mo omk 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) E

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death Date of Death Decedent's Name (First, Middle, Last) October Nielle Physician/ Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death saltimor if Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) Sex **Funeral** Months Min Days 071-62-3816 Director 38 1 □ M 2 🛣 F Yrs 2/10/1973 Usual Residence of Deceder 28a-f show ms 23a or 28a-f sho must be notified at 10a. State 10b. County 10c. City, Town or Location Funeral Director MD Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1750 Long Green Court U.S. 21409 items 2 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, er than "natural", or iter the Medical Examiner 1 Yes 2 No
If Yes, Give
Year or Dates. þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 K No Specify. Specify: Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygien is marked other t 12 5+ Finance Director Health Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Page 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or coll ျှ Maurice Martin Roseanne Lipari 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Toich/Spouse 1750 Long Green Court, Annapolis, MD 21409 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ★ Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Glen Haven Cemetery Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 10/17/2011 22. Name and Address of Facility Signature of Funeral Service Licensee Stallings Funeral Home P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part 1. Enter the disease, or complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Cirrhosis disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 4 Pregnant at time of death 9 Unknown signed by the at Id be detached for 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an Yes To the Hospital or Attending Physician: 25. Was case referred to medical of Vital director Be 26. Place of Death (Check only one) Hospital 2 No Other: 1 Yes မ 1

Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural work 5 Pending injury Division within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) October 14, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 Rina Khatri

07:244

10d. Inside City Limits

1 Yes 2 No

Birthplace (State or Foreign Country)

New York

Black, White, etc.

Month

1 Yes

Black

Approximate Interval Between

Onset and Death

Year

MD 21287

Were autopsy findings available prior to completion of cause of death?

Registrar DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Mory 10:08 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 505 Stanhome Drive Glen Burnie Anne Arundel 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jine 08 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) 1940 1 2M 2 F Months Days Hours Min. Director 218-36-4821 71 Jine MD Usual Residence of Deceden ms 23a or 28a-f shov must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 🗌 Yes 2 🛛 No Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 505 Stanhome Drive 21061 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married 2 ☐ Yes 2 🕅 No f Yes, Give Baltimore, Maryland 21215-0036 1 Tes 2X No White 3 X Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Manager Produce Retail permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Philip Vitale Madeline Manning 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7816 Edgewood Avenue, Pasadena, MD 21122 Robin Vitale (daughter) Date 17 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Oct. 4 ☐ Donation 5 ☐ Other (Specify) Elkridge, Maryland Meadowridge Cemetery 2011 21. Signature of Funeral Service Licer 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Partu. Enter the disease, or completations that cause! the deatt. D shock, or heart failure. List only one cause on each line. not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between nset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence on Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) Pregnant at time of death 1 Yes 2 No ed by the a 9 Unknown P.O. signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 perform certificate 1 ☐ Yes 2 ☐ No 2 25. Was case referred to medical funeral director, Division of Vital 26. Place of Death (Check only one) æ examiner' 1 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending 24 hours after death. 2 Accident
3 Suicide
4 Homicide Investigation 1 🔲 Yes 2 🗌 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check To the within 2 To the I only one) 3 Ertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Datę signed (Month, Day, Year) D 2 201 10 eted cause of death (Item 23) (Type, Print) 445

Registrar
DHMH 17 Rev 7/2009

State

31, Date filed (Mont

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1tem 19a per fh e920 10-19-11 yt
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Rodessia Valentine 23:28 P M 2011 October Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Suburban Hospital Bethesda Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 - M 2 X F Hours 12/30/1979 Washington, DC 579-02-5882 Director 31 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygene.
Titlem 27 is marked other than "natural", or items 23a or 28a-f show other trannatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 950 Mt. Olivet Road, NE 20002 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1X Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: Specify: Black 3 🗆 Widowed 4 🗆 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) DC Government Security 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Valentine Audrey Alston permit. Page 1 and 2 should be Department of Health and Mer Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Valentine 950 Mt. Olivet Road; NE #2; Washington, DC 20002 Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 10/21/2011 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 21. Signatur Funeral Service License 22. Name and Address of Facility Freeman Funeral Services 4594 Beech Road; Temple Hills, MD 20748 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between 0 Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed tran and that initiated events resulting in death) Last Due to (or as a consequence of) been signed by the attending physician a should be detached for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death 2 No Yes Unknown Unknown P.O. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed within 24 hours after deam.

To the Funeral Director. After this certificate is completed filled in by the funeral director, pag-1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No မ 1 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Man of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Patel Jayanti 0052586 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jayanti Patel 8600 Old Georgetown Koach: State Registrar

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Day Year Month FAR L WALLAC 2:25 AM october Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death GOOD SAMPRITAN HOSPITA BALTMORE Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 **X**M 2 □ F 219-28-3804 Months Days Hours Min. **Director** Usual Residence of Decedent r 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director BALTIMORE MD 1 Yes 2 □ No 10e. Street and Number 10g. Citizen of What Country? ıral", or items 23a or Examiner must be Funeral HARWOOD ROAD 21234 USA death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian rmed Forces? Black, White, etc. Yes 2 [If Yes, Give Year or Dates. þ 1 Never Married 2 Married within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: BLACK "natural", 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) PRIVATE OMPUTER ENGINEER 12 Ith and Mental Hygie 27 is marked other r traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) e 1 and 2 should be fill of Health and Mental If item 27 is marked or other traumatic even မ CHARLES WALLACE WASHINGTON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy STOKES-WALLACE (WIFE) 2423 HARWOOD Rd. BALTO, MD. 21234 Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition o permit. Page 1
Department of Important: If it any injury or o cemetery, crematory or other place) Burial 2 ☐ Cremation 3 ☐ Removal from State 10/24/11 BALTIMORE, MD GARRISON FOREST 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility VAUGHN GREENE FINERAL 3 CVS 21. Signature of Funera Service Licensee YORK RUAD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ CENEBROVASCULOR disease or condition ISCHEMIC Medical resulting in death) Examiner I DAY C H 4 PERTENSIAL Sequentially list conditions, Examiner Due to (or as a consequence of). if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No 4 Pregnant at time of death 9 Unknown Month Day Year signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ END-STALL RONAL DISTAGE 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an PNEUMONIA ASPIRATION has autopsy performed certificate 1 Yes 2 No DISTAST CONONAMY mornin 2 No Yes ours after death.

eral Director: After this certification in by the funeral director, I filled in by the funeral director, I 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 1 No Other: Certificate: To Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☑ No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier P 25310 OCTOBBR 12, 2011 JOSON 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MMI MOSOR ALMANT 160 MAVEN BMTIMONE MD 32. Registrar's Signature

DHMH 17 Rev 7/2009

State Registrar 11-07525 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Stephen Adam Woelfl State of Maryland / Department of Health and Mental Hygiene 32920 1. For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3. Time of Death October 7, 2011 1730 hrs **Medical Examiner** Stephen Adam Woelfl 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Franklin Square Hospital Rosedale Baltimore County 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** oreign Months Davs Hours Director Country Germany Aug 7, 1949 1 X M 2 F 217-52-5702 62 Yrs Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d Inside City Limits than "natural", or items 23a or 28a-f show edical Examiner must be notified at once. 1 Yes 2 No Baltimore Baltimore filed within 72 hours after death with the Maryland Director 10e. Street and Number 10a. Citizen of What Country? 8059 Wallace Road 21222 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Armed Forces White, etc. 1 Never Married 2 Married 1 Yes 3 Widowed Specify: white tant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. 12 4 disabled none 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Adam George Woelfl Johanna Schopper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank McCarthy/friend 3015 Vulcan Road Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other Specify ice Licens 21. Signatur (Funeral S.) 22. Name and Address of Facility
State Anatomy Board 655 W, Baltimore Street Baltimore MD 21201
Inter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 23a. Patt I. Enter the disease, or complications that caused the death. Do not enter Approximate Interval **Physician** ke. List only one cause on each line. Between Onset and /Medical Death a, Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial - transit Physician/Medical UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. ğ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was en 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? 1 🗹 Yes Yes 2 No 2 No 25. Was case referred to medical Hospital or Attending Physician: 26.Place of Death (Check only one) Be Hospital: 1 Inpatient Other Nursing Home 5 Residence 6 Other: 2 FR/Outpatient 3 DOA 1 Yes completely filled in by the funeral 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 🗸 Natural 5 Pending 1 Yes 2 No hours after death. 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be determined Homicide 29a. Certif (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 24 Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. October 9, 2011 80. Name and address of person who completed cause of death (Item 23a)

DHMH 17 Rev 1/2001 **OCME 2006**

State Registrar

Laron Locke MD.

OCT 1

OCME

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) October Physician/ 2011 Dorothy Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BAHimore WAShin,ton Burnie more Medical Center GIPN If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign If Under 1 Year Social Security Number 7. Age (In yrs. last birthday) **Funeral** (Month, Day, 1 □ M 2 🗓 F Min 84 Director 217-26-5597 .1927 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f sho Director Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Williams, Durothy Funeral 477 York USA Avenue 21122 New 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 XWidowed 4 ☐ Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Edward Bortner Emma Fick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 477 New York Avenue, Pasadena, MD 21122 Howe - Daughter Carol Baltimore, 20c. Location - City or Town, State 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) any injury or 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory, Inc. Oct 20,2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stallings Funeral Home, PA 3111 Mountain Rd., Pasadena, MD 21122 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line to not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Preumonia Pnysician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner pmenna Sequentially list conditions. Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. physician and the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 Yes 2 X No Month Pregnant at time of death 5 Other (specify) ed by the a a Unknown 9 Unknown been signed by should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? certificate has lirector, page 2 s performed2 1 Yes 2 No 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 2 No 1 Tyes 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) မှ After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3. Time of Death

10d. Inside City Limits

Approximate Interval Between Onset and Death

Year

Day

1 Tyes 2 No

Aryndel

Country)
Maryland

White

1000 AM

Jv State

DHMH 17 Rev 7/2009

Registrar

only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signatu

Secure.

Baltimore Washington Medical Center

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 16b per fh g920 10-20-11 yt
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2, Date of Death CCTOBER Physician/ AM 10 Joseph L Wimpling 201 0:10 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death AGNES HOSPITAL NORE Social Security Number 9. Birthplace (State or Foreign Country)
Maryland 6. Sex 7. Age (In yrs. last birthday) if Under 1 Year If Under 24 Hrs 8. Date of Birth Funeral Days Months Hours Min 1x M 2 □ F October 18,1943 215-42-2035 67 Director Yrs Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any higher or other traumatic event, the Medical Examiner must he matter and once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MT Baltimore Halethorpe 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 1541 S. Rolling Road 21227 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☐ No Specify Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Northrop Grumman College (1-4 or 5+) North Rupgruman Computer Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Joseph B. Wimpling Anna Schlotthober 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen Wimpling-Wife 1541 S Rolling Road Halethorpe Maryland 21227 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Atlantic Crematory Oct 15,2011 Glen Burnie Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home Inc 1328 Sulphur Spring Road Arbutus Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final PNEUMONI Physician, disease or condition Medical resulting in death) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year signed by the a Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 ☐ Unknown 1 \square Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed' certificate 1 Tyes Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 MInpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death filled in by the funeral Certificate: 28b. Time of 28c. Injury at After 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after deat Funeral Director: Suicide 6 Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical within 24 hor To the Fune completed fi 29a. Certifier certifying Physician: to the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: Of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and tipe of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 30. Name and ad ress of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature State park

Registrar

WIMPLING

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month October Physician/ 1:01 WETZEI Medical MARY JANE 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Frederick Frederick Frederick Memorial Hospital Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Y Sep. 23 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** ^{Year} 1933 Min. 1 □ M 2 🕱 F Days Hours Sep. 78 **Director** 220-28-7861 Maryland Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location Director 1 Yes 2 X No Union Bridge Maryland Frederick 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral U.S.A. 13341 Good Intent Rd. · death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Force Black, White, etc 1 Never Married 2X Married 2 **X** No ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) homemaker own home 8 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Eleanor Smith Milton E. Holt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heatth an Important: If item 27 is any injury or other trau Union Bridge, MD 21791 13341 Good Intent Rd. Alfred L. Wetzel Sr./ husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Linganore Cemetery 10/18/2011 Unionville, MD 22. Name and Address of Facility Hartzler Funeral Home 21. Signature of Füheral Service Licen Libertytown, MD 21762 11802 Liberty Rd. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** neumonia Sequentially list conditions, in any, reading to immediate cause. Enter Underlying Examine Fai Cause (Disease or iinjury that initiated events resulting in death) Last The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): physician s the burial Physician/Medical Box 68760 nding puse as t IF FEMALE: fyes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy atten for u in the past 12 months?

1 Yes 2 No Year Pregnant at time of death 5 Other (specify) P.O. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy has death?
1 Yes 2 No certificate Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) funeral n 24 hours after death. te Funeral Director: After th pleted filled in by the funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical

Si

Registrar

within 2

29a. Certifier

only one)

29b. Signature and title of certifier

whene

RATIMA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PANDE

32. Regi**e**trar's Si

DHMH 17 Rev 7/2009

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

400 w 7th St

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

MDD 64910

29d. Date signed (Month, Day, Year)

Frederick, ms 21701

4-2011

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 0900 Physician/ nn 201 th bei Medical 4c. County of Death 4a, Facility Name (if not institution, give street and number) 4b. City Town, or Location of Death **Examiner** N/A 8. Date of Birth 9. Birthplace (State or Foreign If Under 24 Hrs. 7. Age (Ih vrs. last birthday) **Funeral** 5. Social Security Number 238-28-7259 Country Months Days Hours Min. 9/14/25 1 XM 2 - F 86 Director Usual Residence of Decedent 28a-f shov 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director N/A Baltimore MD 1 Yes 2 □ No 10g. Citizen of What Country? or 10e. Street and Number 10f. Zip Code 1715 E. Eager St. - Apt. 23a Funeral 21205 death v or items 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 1 9 4 5
If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian African þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: Amer. "natural" Completed 3 Nidowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumation. Sugar Elementary/Seconday (0-12) College (1-4 or 5+) Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Johnnie Williams, Sr. Martha Battle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number City or Town, State, Zip Code) 214 9th Ave, Bunwick, MD 21, 116 Gerwin Shearin/Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Garrison ForestVA 20c. Location - City or Town, State Owings Mills, MD 20a. Method of Disposition 10/25/11 1 ${f X}$ Burial 2 \square Cremation 3 \square Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hari P. Close F.Svs, PA 5126 Belair Rd, Balt., MD 21206-5105 21, Signature of June al Service | icensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Atherosclerotic Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner cuantially list no citions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) -burialattending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death Day Year s been signed by the should be detached Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an has autopsy performed? Yes 2 No page death? 1 Yes 2 No this certificate **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Yes 2 No ER/Outpatient 3 DOA ျ 1 Inpatient 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending work?
1 Yes 2 No To the Hospital or water death.

To the Funeral Director: Aff completed filled in by the fu 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) City or Town, State) Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and ss of person who completed cause of death (Item 23a) (Type, Print) N

Registrar

Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar F. H. TCHD, Pha. 4locky Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Tracma Bi Itin Con If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 12-23-1944 9. Birthplace (State or Foreign 1 🛛 M 2 🗆 F Months **Director** 66 Bronx NewYork 016-34-9564 Usual Residence of Decedent or items 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Talbot Easton 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8482 Aveley Farm Rd 21601 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔽 No Specify 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done of life. DO NOT use retired) during most of working College (1-4 or 5+) Elementary/Seconday (0-12) President Eye Wear Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Irving H. Appel Gertrude Matlin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda K. Early (wife) 8482 Aveley Farm Rd Easton MD 21601 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State Chesapeake Cremation 4 ☐ Donation 5 ☐ Other (Specify) 9-25-2011 Stevensville, MD Center 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 200 S. Harrison St Easton Signature of Funeral Service Licensee MOHN MERL 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Physician/ Onset and Death disease or condition * unshot Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying CERTIFICATION APPROVED BY MEDICAL Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last tran and Due to (or as a consequence of): burialattending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month 5 Other (specify) Pregnant at time of death Day Year signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has page 2 s After this certificate performed 2 🗌 No Yes 2 X No 1 🗌 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မှ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending injury 24 hours after death 120/2011 inknow 2 No filled in by the Accident Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical

State

сотрыете within 2

Registrar

29a. Certifier

only one)

3

29b. Signature and title of certifier

30. Name and address of person

who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Courtney Ankh E	3on	ds 1- For State Registrar	State of Maryla		nt of Health an te <i>of Death</i>	d Mental Hy	ygiene Reg. 1	2011	32928
Physici Medical Exami		1. Decedent's Name (First,	. / . /	h Bo	nds		2. Date of Death Month Da October 9, 20	ıv Ye <i>a</i> r	3. Time of Death 1202 hrs
,		4a. Facility Name (if not ins 15001 Heath Cen		nber)	4b. City, Town, or Bowie	Location of Death		4c. County of Dea Prince Georg	
Funeral Director		5. Social Security Number 219 - 88 - 52 6	9 1 M 2 F	Age (In yrs. last birthd	ay) If Under 1 Yea Months Days Yrs.		8. Date of Birth(N	1977 9. E	
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Heath and Mental Hygene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show any re other traumantic event, the Medical Examiner must be notified at once.	y Funeral Director	10e. Street and Number 11. Marital Status 1 Never Married 2	nce Georgi Nernors I	Pridge Rd dent Ever in U.S. 1		spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No-	Citizen of What Co LLS A 14. Race - Am White, etc. Specify: R	10d. Inside City Limits 1 X Yes 2 No untry?
5-0036 iled within 72 hours a Hygiene. t other than "natural the Medical Examin	Completed by	15. Decedent's Education Elementary/Secondary (C	4	dui	cedent's Usual Occupating most of working life.	DO NOT use retir		DUSIN	Sewice 1e55
MD 21215-00; 12 should be filed with th and Mental Hygiene 1.77 is marked other ti umatic event; the Med	To Be	ames (19a. Informant's Name/Rela	tionship (Type, Print)	91.	Mailing Address (Stree	(11/1/		City or Town, Sta	te, Zip Code)
		20a. Method of Disposition 1 Burial 2 Crem 4 Donation 5 Oth 21. Senature of Fundral Se	er Specify:		Disposition (Name of cer or other place)	Pk. 101	Date 20	c. Location - City of	or Town, State
Physician Departm Import	4	23a. Part I. Enter the diseas failure. List only one c	e, or complications that cau	used the death. Do not e	P.O. Box 3:	593 WI	respiratory errest,	shock, or heart	Approximate Interval Between Onset and
Examiner	Examiner	Immediate Cause (Final dis or condition resulting in dea Sequentially list conditions, if any, leading to immediate cause. Enter U. derlying Ct (Disease or injury that initial events resulting in death). L	b. Due to (or as a c Due to (or as a c ced c.	onsequence of):	Diabetes Me	llitus			Death
be exe	dical	▼ UNPENDED		3a,27,per i	ne,g921 11-	18-11 sm		23d. Date of delive	
Box 68760 e death c rtificre b the attencing physic ed for us, as the bu	Physician/Me	23b. Was decedent pregnant past 12 months? 1 Yes 2 No 9 ✓	in the 1 Live birt	h 2 nt at time of death 5	Fetal death 3 Other (Specify)	Ectopic pregnar		Month	Day Year
ls, P.O. quires that the en signed by all be detached	2	Part II. Other significant co	enditions contributing to c	leath but not resulting in	the underlying cause g	iven in Part I.		No 3 Pro	the cause of death? bably 4 Unknown utopsy findings available
tal Records, rian: The law requir certificate has been sector, page 2 should la	Completed	25. Was case referred to me	died		00 Diago		autopsy performed 1 Yes 2	prior to	completion of cause of
n of Vital ding Physician h. After this cert funeral directo	n: To Be	examiner? 1 Yes 2 No 27. Manner of Death	Hospital:	patient 2 ER/Outpo	atient 3 DOA		Home 5 Resi		er:
Division pital or Atten ours after death or after death or after death or after death or after death or after death or after or after death o	Certification:	2 Accident 3 Suicide 6 Homicide	Pending Investigation	of Injury - At home, farm		es 2 No luilding, etc.	28f. Location (Stree or Town, State)		ural Route Number, City
To the Hospital within 24 hours To the Funeral completely fille	edical	(g Physician: To the best of Examiner:On the basis of and manner state	examination and/or inve	stigation, in my opinion,	death occurred at	the time, date and	place, and due to t	he cause(s)
	Σ	Alle	Brosse G. VA	3	29c. License O.C.M			d. Date signed (Mectober 10, 201	
		30. Name and address of pe Melissa Brassell, N	MD Assistant Medi	cal Examiner 90	00 W. Baltimore St	treet, Baltimor	e, MD 21223		
Sta	ite	31. Date 1 d Month 2 a 2	32. Regi	strar's Signature	1		<u> </u>	<u> </u>	

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Month Margaret Barbour 2011 рм Sept. 29 2:18 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 M 2 XF Months Days Hours Min Aug. 16, 1919 237-22-9921 Country) 92 Director Usual Residence of Decedent show at 10a, State the Maryland 10c. City, Town or Location Director 10d. Inside City Limits must be notified or 28a-f 1 ☐ Yes 2 🏝 No MD Silver Spring Montgomery 10e. Street and Number 10g. Citizen of What Country? or items 23a Funeral permit. Page 1 and 2 should be filed within 72 hours after death with Department of Heatih and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must b 10314 Calumet Drive 20901 USA "natural", or item edical Examiner m 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No 1 Never Married 2 Married by Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Officer Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Robert Ashby Baker Olive Hopper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth Barbour/Son 10400 Calumet Drive, Silver Spring, MD 20901 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State Sept. 2011 4 Donation 5 Other (Specify) Alexandria, VA Metropolitan Crematory 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. Drian 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Post-Obstructive Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Pulmonary Neoplasm Sequentially list conditions, Examine if any leading to immedia cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician and for use as the bunataransit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 K No Month Day Year Pregnant at time of death signed by the 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed this certificate 1 Yes 2 No 1 Yes 2 XNo 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 🗌 Yes 2 K No ၉ XX Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) in 24 hours after upau... he Funeral Director. After th innleted filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural work? 5 Pending iniury Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, Medical 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2. 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier ٩ 29c. License number 29d. Date signed (Month, Day, Year) D68681 Sept. 29, 2011 lakes 30. Name and address of person who completed cause death (Item 23a) (Type, Print) Charu Maheshwary, MD 1500 Forest Glen Road, Silver Spring, MD 20910 31. Date filed (Month, Day, Year) State 37. Registrar's Signature OCT 03 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 16/2M Clarence Bivens Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HICOMICE TENINSULD **Funeral** If Unde If Under Date of Birth 9. Birthplace (State or Foreign Birthpic Country) VA Hours 08/22/1931 231-36-9796 Director 1 X M 2 🗆 F 80 Usual Residence of Dece or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director V۵ Accomack Temperanceville 1 Yes 2 No 10e. Street and Number 0 10f. Zip Code 10a, Citizen of What Country? must be Funeral 23a 31448 Temperanceville Rd., 23442 **USA** 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, traumatic event, the Medical Examiner 0 þ Black, White, etc. 1 Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural" 3 K Widowed 4 Divorced Specify Completed Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. other than ' Elementary/Secondary (0-12) College (1-4 or 5+) Service Attendant Dept. Of Transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ marked Haywood Bivens Lucy Wise of Health and I 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia B. Strand / Daughter P.O. Box 284, Temperanceville, VA 23442 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Page 1 permit. Page 1
Department of
Important: If it
any injury or o 1 A Burial 2 Cremation 3 Removal from State Shiloh Baptist Cemetery 10/2/2011 4 Donation 5 Other (Speci Atlantic, VA ature of Funera / e // 22. Name and Address of Facility mu Cooper & Humbles Funeral Co., Inc., Accomac, VA 23301 Part 1 Enter the plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. shock, or heart failure. List of Interval Between Onset and Death Immediate Cause (Final disease or condition Ph sician ASC V D Medical resulting in death) Due to (or as a consequence of) Examiner CHF Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) that the death certificate be executed COPD Cause (Disease or injury that initiated events and -trar Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy ☐ Other (specify) ___ in the past 12 months? Month Day Pregnant at time of death Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 performed 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Nonpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 🗌 No Accident
Suicide Investigation 1 🗌 Yes after death 6 Could not be filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral C To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 157952 M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 106

MD.

2017

31. Date filed (Month, Day, Year)
SEP 3

Milford ST. #504B. Salisbury

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For Amend Item	ms 25 per me	laryland Den g920,10/21 Ce	artment of F /2011dhb <i>rtificate of L</i>	Health and I' Death	vlental Hyç ا	giene Reg. N2 0	1 32929
	Dhysisis	/	1. Decedent's Name (First, Midd					2. Date of Dea	ith	3. Time of Death
	Physicia Medic		Patricia Luc					Septemb	er 28, 2	011 12:45 p ^M
¥	Examin	er	4a. Facility Name (if not institution Montgomery Ho		House	,	Location of Death		4c. County of	
Wage .	Funeral		5. Social Security Number	6. Sex 7. Ag	ge (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h I	
	Director		560-20-0075	1 □ M 2 🔀 F	90 Yrs.	Months Days	Hours Min.	Feb. 10	, °1921	9. Birthplace (State or Foreign Country)
	and show 1 at	ě	Usual Residence of Decedent 10a. State 10b. Count	у	10c. City, Town or Lo	ocation				10d. Inside City Limits
	Maryl. 28a-f otifiec	irect	MD Montg	gomery	Silver Sp	ring				1 ☐ Yes 2 🛣 No
	ith the 3a or the n	Funeral Director	10e. Street and Number		-	10f. Zip Code			10g. Citizen of W	hat Country?
	ems 2	nue	3530 Fiske Te	12. Was Decedent	Ever in U.S. 13.	20906 Was Decedent of H		ecify Yes or No-	USA 14 Bace	- American Indian,
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	2	1 ☐ Never Married 2 ☐ Ma 3 🛣 Widowed 4 ☐ Divorce	Armed Forces?	No	If Yes, specify Cuba 1 □ Yes 2 🖾 No	n, Mexican, Puerto	Rican, etc.)	Black	k, White, etc.
15-(72 hou n "nat fedica	Completed	(Specify only high	ent's Education hest grade completed)	(Give	dent's Usual Occup kind of work done of O NOT use retired)	ation du <i>ring m</i> ost of work	ing	16b. Kind of Bus	siness Industry
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pu	filed tal Hyg	To Be	17. Father's Name (First, Middle,	•	· · · · · · · · · · · · · · · · · · ·				Maiden Surname)	
Ŋ	uld be d Men marke natic		Everett L. Je				Wilma P			
, Ma	ind 2 sho lealth an m 27 is i		Tamara Lee Lo		hter 353	ng Address (Street a	errace,	al Route Number Silver S	; City or Town, Sta pring, MI	ate, Zip Code) 20906
Baltimore,	Page 1 a tment of H tant: If ite jury or otl		20a. Method of Disposition 1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other	n 3 Removal from State (Specify)	MD Vetera	matory or other place n's Cemet	ery 0ct.	11	Crownsvi	
Bal	permit Depart Impor any in	,	21. Signature of Funeral Service	Licensee S Charles	F 5	2. Name and Address rancis J. 00 Univer	s of Facility Collins 1 sity Blv	Funeral 1. W., S	Home Inc	oring, MD 20901
				or complications that caused only one cause on each line	d the death. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory arr	est,	Approximate Interval Between
-	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)		ntestinal	Hemorrhay	e			Onset and Death
	Examiner	,	O		a consequence of):					
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8760	tificate ng phy as th		IF FEMALE:				SEKLIFICATION AT			
. Box 68	or Attending Physician: The law requires that the death certificate be executed after death. Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-traile.	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal death 3	Ectopic pregnand Other (specify)	у [23d. Date Mon	e of delivery th Day Year
Division of Vital Records, P.O.	requires that the der been signed by the s should be detached	þ	Part II. Other significant condit	ions contributing to death b	out not resulting in the o	underlying cause giv	en in Part I.			bute to the cause of death? 3 ☐ Probably 4 🏻 Unknown
ord	w requ	Completed				-		24a. Was a	ın 24b. W	ere autopsy findings available
Rec	sician: The law certificate has b irector, page 2 s	No.						autop perfor	med? de	rior to completion of cause of eath? Yes 2 No
ta E	Physician: this certificand in director, is	Be	25. Was case referred to medical examiner?	Hospital:			ace of Death (Chec			pice
Ž	Physical this carral direction	<u>۲</u>	1 X Yes 2 No 27. Manner of Death		ent 2 ER/Outpatie		4 ☐ Nursing He		ence 6 🖾 Other	(Specify)
o U C	ttending Phydeath.	icate	1 Natural 5 ☐ Pendi 2 ☐ Accident Invest			work	? Yes 2 \Bar No	Zod. Describe III	ow injury occurred	
INISI	I or Atteno after death Director: /	Certificate:	3 Suicide 6 Coulc 4 Homicide determ		ury - At home, farm, str c. (Spec <i>ify)</i>	eet, factory, office		28f. Location (S City or Town		or Rural Route Number,
	To the Hospital of within 24 hours at To the Funeral D completed filled it	Medical	(Check 2 L Medical	g Physician: To the best of Examiner: On the basis of e. g Nurse Practioner: To the	xamination and/or inves	tigation, in my opinio	n, death occurred a	t the time, date ar	nd place, and due	to the cause(s) and manner stated.
	vithir To th	4	29b. Signature and title of certifie			29c. License	number			(Month, Day, Year)
	$l^{\mathcal{O}}$		30. Name and address of person	who completed cause of d	CRNP		R143201		4/2	0/11
			Debrah Mille:		55 Piccard		ockville,	MD 208	50	
	Stat Registra	-	31. Date filed (Month, Day, Year) SEP 30	2011 Registra	ar's Signature	ped.				

fax to ME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Maryland / De	epartment of F Certificate of L		Mental Hygie	2011	32930
1	Physicia Medic		1. Decedent's Name (First, Middle, Last) Elena	Cox			2. Date of Death	6 ^{ay} 201 1 ^{ear}	3. Time of Death 11:50 aM
132	Examir		4a. Facility Name (if not institution, give s 10119 Brunette		4b. City, Town, or Silv	Location of Death	ng	4c. County of Deat	omery
	Funeral Director		5. Social Security Number 6. Sex 579-62-0648 1 Usual Residence of Decedent	7. Age (In yrs. last birthda	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth 9 12 19		thplace (State or Foreign goslavia
	faryland Ba-f show tified at	Director	10a. State 10b. County Md Montgon	nery 10c. City, Town or Silv	er Spring	J.			10d, Inside City Limits 1 ☐ Yes 2 ※ No
	with the N s 23a or 2 ust be no	Funeral Di	10e. Street and Number 10119 Brunette	e Avenue	10f. Zip Code 209	01	10g	. Citizen of What Co USA	ountry?
9003	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ♣No If Yes, Give Year or Dates.	13. Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🔀 No		ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: Wh	e, etc.
Maryland 21215-0036	within 72 ho giene. er than "nat , the Medica	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	(Gallage (1.4 or 5.)	ecedent's Usual Occup ive kind of work done o e. DO NOT use retired) ditor	ation during most of work	ring	b. Kind of Business. Federal	
land	d be filed of the firked other tic event,	To Be	17. Father's Name (First, Middle, Last) Peter Fortuna	tow		18. Mother's Nam Natal	ne (First, Middle, Maid .ia Shch	_{den Surname)} nutskaya	ı
, Man	id 2 should be fill salth and Mental n 27 is marked o er traumatic eve		19a. Informant's Name/Relationship (Type Esperanza Marki		ailing Address <i>(Street a</i> 16 Fayett				
Baltimore,	Page 1 an ment of He ant: If iten ury or oth		20a. Method of Disposition 1 → Burial 2 → Cremation 3 → F 4 → Dopation 5 → Other (Specify)	Removal rom State cemetery of ROCK	isposition (Name of crematory or other place Creek Ce	em 9/28	3/2011	Wash.,D.	.C.
Balt	permit. Page 1 Department of Important: If i any injury or once.		21. Signatur Funeran Service License	ben for	Phydelpade 9241 Colu	RTNALD] umbia B]	FUNERAL	L SERVIO er Sprin	CE,P.A. ng,Md20910
	hysician/		23a. Part 1. Enter the disease, or compl shock, or heart failure. List only one Immediate Cause (Final disease or condition			g, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death 1 vear
	Medical Examiner	,	resulting in death)	Due to (or as a consequence of): Liver failur					
	outed nd	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence or).					
	ite be executed hysician and the burial-ira	lical	resulting in death) Last	Due to (or as a consequence of):		- -			
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ecord	ne law require e has been si age 2 should	Completed					24a. Was an autopsy performed	prior to death?	utopsy findings available completion of cause of
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Division of Vital Records,	ding Phy n. After this funeral c	은	1 ☐ Yes 2 ♣ No 27. Manner of Death 1 ♣ Natural 5 ☐ Pending	1 Inpatient 2 ER/Outpa 28a. Date of injury (Month, Day, Year) 28b. Tim injur	e of 28c. Injury	4 ∐ Nursing Hey y at	ome 5 Residence 28d. Describe how i		cify)
ivisio	To the Hospital or Attending Phy Within 24 hours after death. To the Funeral Director. After this completely filled in by the funeral	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)		103 2 110	28f. Location (Stree City or Town, S		ural Route Number,
	le Hospita n 24 hours le Funeral oletely fille	Medical	(Check 2 Medical Examin	cian: To the best of my knowledge, dea er: On the basis of examination and/or in Practitioner: To the best of my knowle	vestigation, in my opinio	on, death occurred a	t the time, date and p	lace, and due to the	cause(s) and manner stated.
	36		29b. Signature and title of certifier	non	29c. License D	number 35656	29d.	. Date signed (Mont Sept . 2	7, 2011
			30. Name and address of person who co	M.D. 8830 Came	eron St.#	402 Silv	ver Spri	ng,Md 2	0910
	Sta Registra		31. Date filed (Month, Day, Year) SEP 3 0 2011	37 Registrar's Signature	ales				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Physician Medica Examine Funeral Director

	1 - For State Registrar			Cer	tificate of l	Death			Reg. N	20		32931
,	1. Decedent's Name (First, Middle, Las							2. Date of De Month	ath		Vear	3, Time of Death
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r	4a. Facility Name (if not institution, give	street and numbe	er)		4b. City, Town, o	r Location of	of Death		40	,	of Death	
	Union Hospital 5. Social Security Number 6. Se	ay 7	Age (In yrs. Ia	et hirthday	E1kton If Under 1 Year	If Under	21 Hrs	8. Date of Bir	*6	Ce	ecil	
		⊠ M 2 □ F	75	Yrs.	Months Days	Hours	Min.	(Month, De		, I	9. Birth Cour	place (State or Foreign htry) Canada
	Usual Residence of Decedent				L			0/30/	175	J 1		- Janada
ior	10a. State 10b. County		10c. City	, Town or Loc	cation							10d. Inside City Limits
Funeral Director	MD Cecil		E1	kton								1 🗆 Yes 2 🕱 No
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ğ	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 If Yes, Give Year or Dates		1	☐ Yes 2 🙀 No	Specify:				Specify:	: W	hite
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	Edwin David Conge					Sy1	via (Carlson				
	19a. Informant's Name/Relationship (Ty				g Address (Street						State, Zip	Code)
	Kay Sciarra - wif	:e	20h P		no11wood sition (Name of						O'4 T	own, State
	1 ☐ Burial 2 🗓 Cremation 3 🗆		ate C6	emetery, crem	natory or other plac	i	-	5°/2011			•	
	4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service License	_	[R.T.	· Foard	Funeral Name and Addre	Home	, PA	n na 1	Ri	sing	Sun	, MD
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	shoot, or heart failure. List only or	ne course on each										
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State Registrar

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permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items; any injury or other traumatic event, the Medical Examiner must once.

Physician/ Medical **Examiner**

that the death certificate be executed

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the dewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached

Baltimore, Maryland 21215-0036

31. Date filed (Month, Day, Year) 0CT 03 2011

DANIO GAR-EL

32. Registrar's Signature pare

304-306 NORTH STEET

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SULTE \$ 3 ELETON MARYLAND

21921

CR S

DHMH 17 Rev 1/2001

OCME 2006

State 31. Date filed (Month, Day Ye Registrar 0 C 1 0 4 201

Ana Rubio MD.

32. Registrar

Signature

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

O.C.M.E.

September 26, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 23 2011 19:51 CARTER MOSES Μ. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Prince Georges Clinton 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days Hours June 4, 1 🖾 M 2 🗆 F VA **Director** 579-20-0763 87 Usual Residence of Decedent 28a-f show or items 23a or 28a-f sho miner must be notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director 1 X Yes 2 □ No DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 5318 Gay St NE 20019 death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 1943 Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Examiner Black White etc 1 Never Married 2 Married Completed by Saltimore, Maryland 21215-0036 וan "natural", נ Medical Exam 1 ☐ Yes 2 No Specify. Specify 3 X Widowed 4 ☐ Divorced Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Department of Health and Montal Hygene.
Important: If item 27 is marked other than "na any injury or other traumatic event" (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) US Postal Service 12th Postal Clerk Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Ida Carter Moses P. Carter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Riverdale, MD 20737 5906 Magnolia Hill Lane Angela McLaughlin - Daughter 20a. Method of Disposition 20h Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Harmony Memorial Park 10-3-2011 Landover, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Funeral Home of Maryland 4308 Suitland Rd. Suitland, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death AU Imavera Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of Exami and Due to (or as a consequence of) resulting in death) Last burial attending physician for use as the buria Physician/Medical certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death g 🗌 Unknown 9 Unknown P.O. I signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy page performed? death? 2 🗌 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) 2 No 1 Tyes မ 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Acciden 5 Pending injury work? 1 \(\text{Yes} \) 2 🗌 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check only or Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signaty e and title of certifie

State

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Registrar

31. Date filed (Month, Day,

ne and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. N.2 N Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Edward D. 2011 Cranford 12:32 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death St. Thomas More Prince George's Hyattsville Social Security Number Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 1 X M 2 □ F Hours Min. (Month, Day, 1952 New York Director 104-44-4024 59 March Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at illed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits NJ Sussex Hopatcong 1 X Yes 2 No 10e. Street and Numbe 10f Zip Code 10g. Citizen of What Country? Funeral 5 Vale Way 07843 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No or i Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give "natural" Specify: White 3 ☐ Widowed 4 ☑ Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Chemical Compounder Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental I is marked o ပ Edward Cranford Elizabeth Schank l and 2 should b f Health and Mei tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Meghan Cranford / Daughter 211 Jasmine Cove Circle Simpsonville, SC 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, permit. Page 1 a
Department of H
Important: If ite
any injury or otl 20c. Location - City or Town, State 1 🗆 Burial 2 🔀 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Fort Lincoln Crematory 10/3/11 Brentwood, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Rd. Brentwood, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician/ Cardiovascular Diseas Arterioscharatic disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year Yes 2 No the 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ End Stage Renal Disease [Hemodralyses Completed 1 Yes 2 No 3 Probably 4 Unknown Respiratory Failure Centilator Deprindent 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? Tracheal Stenosis Paraconsmal Atmial fibrillation 25. Was case referred to medical examiner? Be (26. Place of Death (Check only one) 1 ☐ Yes 2 🗷 No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA this 4 M Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending Accident
Suicide 1 Tyes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined م 24 hour the Funeral Dire حط filled in Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Hose within 24 ho Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier Jeptember 28,2011 Gueers burn

DHMH 17 Rev 7/2009

State Registrar

amPlease Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ GEORGE CARRICK 6.45 A 24 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death Baltimore Genesis MI 1stown 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X**M 2 □ F Min. Months Hours 47 Washington, D.C. 64 **Director** Usual Residence of with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified Randallstown 28a-f Maryland Baltimore 1 Yes 2 No ō 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? must be r Funeral USA 21133 9109 Liberty Road items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. þ ö 1 Never Married 2 Married 1 Yes 2 No 1966 If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify white "natural" Completed 3 Widowed 4 Divorced Year or Dates 1969 the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. 4 College (1-4 or 5+) Elementary/Seconday (0-12) Technician Xerox Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H if item 27 is marked ot r other traumatic ever မ Gelrge Alton Carrick Margaret Vesper George Alton Carrick 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4698 Breezy Pines Boulevard, Sarasota, Florida
34232 19a. Informant's Name/Relationship (Type, Print) nt of Health a : If item 27 is Keith Carrick - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Department o Important: If any injury or once, ō 10-2-2011 Stauffer Crematory Frederick, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Ventricu disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or linjury that initiated events Due to for de a concecuario a chi -transit and Due to (or as a consequence of) resulting in death) Last burialattending physician Physician/Medical certificate be P.O. Box 68760 the as 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: A At 23b. Was decedent pagnant use 23d. Date of delivery in the past 12 months? for Dav Year Yes 2 No the detached 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Heppercapnia, Obstructive Division of Vital Records, 1 ☐ Yes 2 Ano 3 ☐ Probably 4 ☐ Unknown Completed page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autops death? Mulbid Yes 2 No 200 No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 2 No Other: မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4. Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral or 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending NA 1 Tes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29d, Date signed (Month, Dav. Year) D0072109 0 Pr 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Most SADVA ls tou egistrar's Signati State BRRAG Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amended, #5 For TCHD, 10/07/20 state of Maryland / Department of Health and Mental Hygiene Registrar F. H., TCHD, PRoc., 9/26/10 Certificate of Death

1. Decedent's Name (First, Middle, Last)

Reg. No. 32936 3. Time of Death Physician/ 9^{Mo}2^t0-201 Pay 7:26 P M Geraldine S. Churchill Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 21410 Avalon Ct Tilghman Talbot 5255cgl Seguety Nymber 4 If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Days ^{Coun}Minnesota 1 □ M 2 🗓 F 1 (Month 2 Day 1 930 80 03-5015 **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County death with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Talbot Tilghman 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21410 Avalon Ct. 21671 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black. White, etc. þ 1 Never Married 2 Married Saltimore, Maryland 21215-0036 filed within 72 hours after Yes 2 X No If Yes, Give Year or Dates. 1 ☐ Yes 2 😾 No Specify: "natural", Specify: White 3 XWidowed 4 ☐ Divorced Completed traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Seconday (0-12) 12 College (1-4 or 5+) Homemaker Own Home Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Inportant: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Edwin Theodore Severson Myrtice Ellen Sills 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark Churchill (Son) 21410 Avalon Ct Tilghman, MD 21671 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Chesapeake Cremation 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Stevensville, MD Center 9-21-2011 Fellows, Helfenbein & Newnam Funeral Home, P.A. 200 S. Harrison St. Easton, MD 21601 21. Signature of Funeral Service Licensee ROA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ erebra Vascu disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examiner il any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of, attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Dav the 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 s autopsy performe 2 No Yes 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital Other: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 28d. Describe how injury occurred Natural 5 Pending injury Accident illed in by the f Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined 29a. Certifier Lectifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours a To the Funeral D (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month. Day. Year) September 21,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Guston 2/40 Inwood MI -10-State Registrar DHMH 17 Rev 7/2009

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	he Ho in 24 l he Fu ipleter	Med	(Check 2 Medical Examiner: On the basis of examination are only one) 3 Certifying Nurse Practioner: To the best of my kn	nd/or investi	gation, in my opinior	, death occ	curred at the time	e, date and	place, and due to	the cau	use(s) and ma	nner stated.
	To the within 2 To the comple		29b. Signature and title of certifier	\	29c. License	number	. 0	29	d. Date signed (/			. (
			and to an diet M	1	D39	504	18		9/2	. 2	1201	1
	6		30. Name and address of person who completed cause of death (Item 23 ERIC F. CIGANEK, M.D., 629 RAILS	ROAD A	VENUE, C	ENTRE	EVILLE,	MD 21	617			
	Stat	е										
	Registra	r	SEP 26 2011 Lane B.	140								

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend 26 per DVR G920 10/31/11 dk
State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. N2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year e 201. Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner hesapean Anne The If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vis. last birthday **Funeral** 1 M 2 XF Months Days Hours Mir Country) **Director** or 28a-f show 10a. State be filed within 72 hours after death with the Maryland injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Yes 2 ☐ No DO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates Specify: "natural", B Specify: 3 Widowed 4 Divorced 100 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) aundry Be 17. Father's Name (First, Middle, Last) မ permit. Page 1 and 2 should be Department of Health and Men Important; If item 27 is marke any injury or other traumatic Son 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Rou Number, City or Town, Kinle terinuspana Anna Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Donation 5 Other (Specify) Signature of Inneral Service Licensee 22. Name and Address of cility Dove Easton, M/21601 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition 4Car Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death Unknown cate has been signed by the a page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perforn death? 24 hours after death. Funeral Director: After this certificate 2 🗌 No 1 Yes Yes director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 2 (No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 K Residence 6 🗵 Other (Specify) Manner of Deat

1 Natural
2 Accident
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4 Homicide completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 5 Pending work 1 Tes 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 or ly uns Certifying Nurse Practioners To the best of my knowledge, death occur et the time. date and place, and due to the page stell and manner as etate 29b. Signature and title of certifier eptember 23, 2011 e weins 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #210, Annapolis, MD 21401 hedical Parking Werner 13 31. Date filed (Month, Day, Year) Registrar's Sig SEP 27 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 32939 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Katherine Seward Dai1 2011 9:00 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death Wicomico Social Security Number If Under **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🕱 F Months Days $JuT_{\mathbf{y}}^{Month}1^{Day}$ Hours Year 923 218-16-5715 Maryland Director 88 Usual Residence of Decedent 28a-f show at 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-fs event, the Medical Examiner must be notified MD Dorchester Cambridge 1 X Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 518 Glenburn Avenue Apt. 306 21613 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No ò Black, White, etc. RAHMING LUIL Baltimore, Maryland 21215-0036 1 Never Married 2 Married white If Yes, Give 1 ☐ Yes 2X No Specify: 3 Midowed 4 ☐ Divorced Specify: Completed Year or Dates Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 | h and Mental Hygiene. 7 is marked other than "n (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) clerk wire cloth mfg. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 William Russell Seward permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke, any injury or other traumatic. Anita North other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Larry E. Dail 22 Bellevue Avenue, Cambridge, MD son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 K Burial 2 Cremation 3 Removal from State Spedden Seward Cem. 4 ☐ Donation 5 ☐ Other (Specify) 9/29/11 Cambridge, MD Signature of Funeral Ser 22. Name and Address of Facility Thomas Funeral Home P.A. ice Licensee 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ CARDIO 1440 Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate Physician/Medical Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 onths?

1 Yes 2 No
9 Unknown Day Month Year Pregnant at time of death the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed Completed by 23e. Did tobacco use contribute to the cause of death? 2 PNo 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has braid director, page 2 s autopsy performer death? within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 1 Tyes Other: 1 Inpatient 2 I HOSPICE ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) h

DHMH 17 Rev 7/2009

State

Registrar

Registrar's Signature

180

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SEP 28 20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 29 Patricia Ann Davis 20°1′1 12:21 pM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4344 Centennial Road East New Market Dorchester 5. Social Security Number 6. Sex If Under 1 Year I if Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 X F Hours July 8, Year 946 577-62-3429 Marty land Director 65 Usual Residence of Decedent shov 10a. State ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Dorchester East New Market 1 Yes 2 K No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4344 Centennial Road 21631 USA 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married þ 1 Yes If Yes, Give 3altimore, Maryland 21215-0036 2 🙀 No 1 ☐ Yes 2 🗷 No Specify: white "natural", 3

Midowed 4 □ Divorced Completed Specify: Year or Dates. d Mental Hygiene. marked other than "natur matic event, the Medical I 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) homemaker $\tilde{1}\tilde{2}$ own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I permit. Page 1 and 2 should be f Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev 0 Kenneth Miles Katherine Landon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa R. Welcher daughter 3414 Beaver Neck Road, Cambridge, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State injury or 1 Burial 2 X Cremation 3 Removal from State Crematory of Delmarva 9/30/11 4 ☐ Donation 5 ☐ Other (Specify) Delmar. DE 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Pregnant at time of death 5 Other (specify) ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No 1 Yes æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) this 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 Watural 5 Pending work? 1 ☐ Yes 2 ☐ No To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Aft completed filled in by the fur Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00053255 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Preston Road

State Registrar 31. Date filed (Month, Day, Year)

3683 Chaptank

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 3294 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Norman 3°0 **.** Leroy Davis 12:30 PM September 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Sex 1 ☐ M 2 ☐ F Min. Months Days Hours June 18, 1 Country) 77 Director 236-48-3635 WV 1934 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No MD Montgomery Rockville ò 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral 4401 Falcon Street 20853 USA death 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 Daylor If Yes, Give Korean Year or Dates. Conflict 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify Specify: Completed 3 Divorced 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Police Officer Law Enforcement of Health and Mental Hygie fitem 27 is marked other r other traumatic event, tt Be permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked oth any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, 6 Floyd Davis Junita McKee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hildegarde Davis/Wife 4401 Falcon Street, Rockville, MD 20853 20a. Method of Disposition Oct. 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 **Cremation 3 ** Removal from State cemetery, crematory or other place Metropolitan Crematory 2011 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA neral Service License Francis de Address de Francis Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final ostate Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Secuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a con resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy
 5 Other (specify) Pregnant at time of death Month Day Year 9 Unknown Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, has been sign e 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? page performed? Yes 2 2 🗌 No 1 🗌 Yes Vital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 20 No 1 Inpatient 2 ER/Outpatient 3 DOA Other: 일 4 Nursing Home 5 Residence 6 Other (Specify) 5 27. Manner of Death Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending injury Division Accident Suicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29c. License number 66264 29b. Signature an date of certifie 29d. Date signed (Month, Day, Year) iÒ

State Registrar 8600 Old Georgetown Road, Bethesda, MD 20814

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

Babak Pirouz, MD

31. Date filed (Month, Day, Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ GORDON KENT DOWERY SEP 2011 3:30 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death WRNMMC MONTGOMERY BETHESDA Social Security Number 9. Birthplace (State or Foreign Country) Maryland **Funeral** 6. Sex 7. Age (In vrs. last birthday If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 1 X M 2 🗆 F 78 **Director** 218-24-1437 Usual Residence of Decedent 28a-f sho with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director iral", or items 23a or 28a-f sl Examiner must be notified Montgomery Silver Spring 1 Yes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13513 Collingwood Terrace 20904 u.s.A. filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. X Yes 2 No 1955-Yes, Give þ 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 Yes 2 No Specify. "natural", Completed 3 X Widowed 4 Divorced Black Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the U.S. Army Director Be 17. Father's Name (First, Middle, Last) t. Page 1 and 2 should be filed tment of Health and Mental H Bant: If item 27 is marked ot 18. Mother's Name (First, Middle, Maiden Surname) 2 John Dow Gertrude Doweary 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nathaniel Dowery - Son 13102 Buccaneer Road, Silver Spring, Maryland 20904 Increment of H Increment: If iten any minn 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Baltimore Czematory at Loudon Park 1 🗆 Burial 2 🕱 Cremation 3 🗀 Removal from State 09/30/2011 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home menosta 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ CONGESTIVE HEART FAILURE Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Examine Day to for as a gunseournes of Cause (Disease or linjury that initiated events resulting in death) Last ACUTE RENAL FAILURE and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ 23d. Date of delivery in the past 12 months? Pregnant at time of death Day Year ed by the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 🛛 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 autopsy performed? 1 Yes 2 X No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 XNo 욘 1 X Inpatient 2 ER/Outpatient 3 DOA this 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral or 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 XNatural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 15+1 2 0 10386 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DEZEE, WRNMMC, BETHESDA, MD 20889 5600 KENT LTC,

Registrar

MD

31. Date filed (Month, Day, Year)

OCT 03 2011

11-07266

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Vance Dunkley	1- For State Ce	partment of Health and Mental Fertificate of Death	Hygiene 2011 329	43
Physiciar Medical Examin			2. Date of Death Month September 26, 2011 3. Time of Death 2004 hrs	
	4a. Facility Name (if not institution, give street and number) McCready Memorial Hospital	4b. City, Town, or Location of Dea Crisfield		
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. 054–56–8872 1 🗷 M 2 F 50	last birthday) If Under 1 Year If Under 24H Months Days Hours Mi Yrs.	1-	ork
м апу		y, Town or Location	10d. Inside City	
Aaryland	Maryland Somerset	Marion Station	1 Yes 2	≦ No
with the Maryland ns 23a or 28a-f sho be notified at once.		21838	U.S.A.	
215-0036 be filed within 72 hours after death with the Maryland mal Hygiene. rked other than "natural", or items 23a or 28a-f she ent, the Market Examiner must be notified at one.	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Yes 2 X No	U.S. 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	o Rican, etc.) White, etc.	
rs after	3 Vidowed 4 Divorced in res, Give rear or Dates:	1 Yes 2 No specify:	Specify: White	
5-0036 ed within 72 hour stygiene. other than "natt	Elementary/Secondary (0-12) College (1-4 or 5+)	16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use re	tired)	
5-003(led within Hygiene.	17. Father's Name (First, Middle, Last)	Chef 18.Mother's Nam	Pastry le (First, Middle, Maiden Surname)	-
- 0 m > 1	Vernon Dunkley 19a. Informant's Name/Relationship (Type, Print)		h Ellis	
Baltimore, MD 21 permit. Pages I and 2 should Department of Health and Me Important: If item 27 is ma injury or other traumatic ver	Vanesa Isakson (Sister)			338 1D
ore, less and of Healt If item	20a. Method of Disposition 20b. 1 Burial 2 Cremation 3 Removal from State	Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City or Town, State	<u></u>
Baltimore, permit. Pages 1 a Department of He Important: If ite injury or other to	4 Donation 5 Other Specify:	ematory of Delmarva 09	/28/2011 Delmar, DE	
Bal permi Depa Impo	21. Signatur of Funeral Service Licensee Robert H. Bradshaw Tr	22 Name and Address of Facility Bradshaw & Sons Fu 306 W. Main StCr	neral Home isfield, MD 21817	
Physician /Medical	23a. Part I. Enter the disease, or complications that caused the death failure. List only one cause on each line.	Do not enter the mode of dying, such as cardiac	or respiratory arrest, shock, or heart Approximate Int Between Onset	
Examiner	Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiov		Death	
	Sequentially list conditions, b	ot).		
led nsit	(Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of			
50, te be execu ysician and burial - tra	UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of prec			
Box 68760, death certificate be he attending physic of for use as the burnweician/Med	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnant in the past 12 months?	2 Fetal death 3 Ectopic pregn	23d. Date of delivery ancy Month Day Year	
D. Boy t the deatl by the att ached for Physi	9 Onknown	resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death	2
ires that the signed by lee detacl	chronic alcohol abuse	esulting in the underlying cause given in Part I.	1 Yes 2 No 3 Probably 4 Unknown	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buil edical Certification: To Be Completed by Physician/Medicalical Certification:			24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 N	e of
Ital Recions: The certificate rector, page	25. Was case referred to medical examiner?	26.Place of Death (Check	only one)	
of Vital ng Physician of Physic	1 V Yes 2 No Impatient 2 V	ER/Outpatient 3 DOA Other Nursin 28b. Time of Injury 28c. Injury at Work?	ng Home 5 Residence 6 Other: 28d. Describe how injury occurred	
ttendin death. stor: A: the fur	1 V Natural 5 Pending (Month, Day,Year) 2 Accident Investigation	1 Yes 2 No		
Division o Division of Attending within 24 hours after death. To the Funeral Director: Aft completely filled in by the fune		ome, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, or Town, State)	City
To the Hos within 24 h To the Fun completely	29a. Certifier 1 Certifying Physician: To the best of my knowled one) 2 Medical Examiner: On the basis of examination a and manner stated.	ige, death occurred at the time, date and place, and and/or investigation, in my opinion, death occurred a	I due to the cause(s) and manner as stated. at the time, date and place, and due to the cause(s)	
E STORE	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)	
the	30. Name and address of person who completed cause of death (Item	,	September 27, 2011	
State		900 W. Baltimore Street, Baltimore,	MD 21223	
State Registra		par		
DHMH 17 Rev 1/2001		ORIGINAL	OCME	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Maryland / Depart		1ental Hygier	ie 2011	22011
			State Registrar		rtificate of Death	Reg. I	NG UII	32944
	Physicia Medi		1. Decedent's Name (First, Middle, Last)	Daniels		2. Date of Death Month	Day Year 7 - 2011	3. Time of Death 2021 PM
"Saycard	Examir	ner	4a. Facility Name (if not institution give s	- Horalal	4b. City, Town, or Location of Death	Spring	4c. County of Death	gomery
1	Funeral Director		0 10 10 199	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year	9. Birth Cour	place (State or Foreign ntry) VII GIMA
	ryland I-f show ied at	Director	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo		a		10d. Inside City Limits
	th the Ma 3a or 28a t be notif		10e. Street and Number	0	Jung to Do	10g.	Citizen of What Cou	1 🖫 Yes 2 🗆 No
	death wi	Funeral	11. Marital Status	20ma Uve St 12. Was Decedent Ever in U.S. Armed Forces? 1 🗸 Yes 2 🗆 No	Was Decedent of Hispanic Origin? (Spef Yes, specify Cuban, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
-0036	ours after atural", o cal Exami	eted by	1 Never Married 2 Married 3 Widowed 4 Divorced	If Yes, Give Year or Dates.	1 ☐ Yes 2 ☐ No Specify:		Specify: Bi	ack
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	(Specify only highest grace	de completed) (Give I	dent's Usual Occupation kind of work done during most of worki O NOT use retired)	ng 16b.	None	ndustry
Maryland	ld be filed Mental Hy, arked oth atic event	To Be	17. Father's Name (First, Middle, Last)	Daniels	18. Mother's Name	e (First, Middle, Maide Llean		erburk.
	and 2 should Health and Mi tem 27 is mar ther traumati		19a. Informant's Name/Relationship (Type	in els/wife 612	ng Address (Street and Number or Rura	Route Number, City	or Town, State, Zip	code) SC 20002.
Baltimore,	Page 1 ar nent of He ant: If iter ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		natory or other place)	20c.	Location - City or To	
Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licenser	Pulger 90	Name and Address of Family 11	Rd Lan	Funera ham, m	D ZOTOGE
Jan.	e Physician	0 1	23a. Part 1. Enter the disease, or compli shock, or heart failure. List only one Immediate Cause (Final disease or condition	/\ i .	er the mode of dying, such as cardiac o	,	Kan	Approximate Interval Between Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a consequence of):	unodeficiency	Sundan	, , , ,	
	uted Id ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	Due to (or as a consequence of):	-			
09	death certificate be executed the attending physician and set for use as the burial-transit	dical Ex	resulting in death) Last	Due to (or as a consequence of):				
6876	eath certificat attending ph I for use as th	ın/Mec	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of pregnancy			23d. Date of deliv	rerv
	the death by the atte ached for	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live Birth 2 Fetal death 3 4 Pregnant at time of death 5 Unknown	Other (specify)		Month	Day Year
	s this	by	Part II. Other significant conditions con	tributing to death but not resulting in the ur	nderlying cause given in Part I.		o use contribute to the	he cause of death?
Division of Vital Records,	The law requires ate has been sign page 2 should be	Completed				24a. Was an autopsy performed?	prior to co	psy findings available impletion of cause of
<u> </u>	rsician: The law s certificate has b lirector, page 2 s		25. Was case referred to me * al examiner?	-	26. Place of Death (Check	1 🗆 Yes 2 🗗		2 🗆 No
֡֞֞֟֝֟֝֟֝֟֝֟֝֟֝֟֝֟֝֟֡֟֝	Physic this ce al dired	욘	1 Yes 2 No	ospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 28a. Date of injury 28b. Time of	Table 1	ne 5 🗆 Residence)
o uo	ending eath. or: After he funel	Certificate:	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	28c. Injury at work? M 1 ☐ Yes 2 ☐ No	8d. Describe how inju	ary occurred	
DIVIS			3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm, stre building, etc. (Specify)	et, factory, office	28f. Location (Street a City or Town, Star		l Route Number,
:	the Hosp nin 24 hou the Funer npleted fil	Medical	(Check 2 L Medical Examine	cian: To the best of my knowledge, death oner: On the basis of examination and/or investion Practioner: To the best of my knowledge, death of the basis of my knowledge, death of the basis of my knowledge, death of the basis of my knowledge, death of the basis of my knowledge, death of the basis of my knowledge, death of the basis of the basis of my knowledge.	gation, in my opinion, death occurred at	the time, date and place	ce, and due to the ca	use(s) and manner stated.
	vitt Con		29b. Signature and title of certifier	D	29c. License number 0 0 0 6 0 1 0 0	29d. D	Oate signed (Month, 1	Day, Year)
2	3		30. Name and address of person who con	mpleted cause of death (Item 23a) (Type, Pr	29c. License number 00060100 rint) 1 mo Lar	7 14 Ai	Ju tos	
	Stat Registra	_	31. Date filed (Month, Day, Year) OCT 0 4 2011	32. Registra 's Signature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Reg. No Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Lewis Robert Dalton September 22 2011 8:56 Рм Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, June 23 If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign 1 XM 2 | F Davs Hours Year Country) Maryland Director 215-46-0014 Yrs. 66 June 1945 Usual Residence of Decedent 28a-f shov 10a. State 10b. County with the Maryland Examiner must be notified at by Funeral Director 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Maryland Frederick Frederick 23a or 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 10317 Putman Road 21702 United States items ; permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. 11. Marital Status Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. "natural", or 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify. Specify: White 3 Divorced Completed er than "natur , the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha 12 Driver U. S. Postal Svc. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Robert Taylor Dalton Claire Ida Rothbart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Department of Health Important: If item 27 any injury or other tronce. Nancy Dalton/ Wife 10317 Putman Road, Frederick, Maryland 21702 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory Inc. 9/26/2011 Frederick, Maryland Signature of uneral Service Licena 22. Name and Address of Facility Stauffer Funeral 1621 Opossumtown Prederick, Maryland 21702 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition 400 Medical resulting in death) ue to (or as a consequence of) Examiner Rena ekronic -cute ure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events ON Due to or as a consequence of): Exami as the burial-transit Renat ac P cance Monty and resulting in death) Last Due to (or as a consequence of): ttending physician Physician/Medical certificate be IF FEMALE or use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ___ in the past 12 months? Day Pregnant at time of death Month Year 2 No the 9 Unknown Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe After this certificate Yes 2 25. Was case referred to medical director, Be 26. Place of Death (Check only one) Hospital 2 Other: 1 Yes မ 1 Propatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural Accident 5 Pending injury Investigation М 1 \square Yes 2 🗌 No

Box 68760 To the Hospital or Attending Physician: The law requires that the death Division of Vital Records, P.O. within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of

> 19 State

Medical

6 Could not be

determined

who completed caus

4GAR

Suicide

Homicide

29a. Certifier (Check

only one) 29b. Signature

31. Date filed (Mo

30. Name and address of person

Registrar

DHMH 17 Rev 7/2009

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Gertifying Narse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number MDD 65378

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

of death (Item 23a) (Type, Print)

01

32 Registrar's Signatur

BERT

28f. Location (Street and Number or Rural Route Number, City or Town, State)

.400 West 7th Street, Frederick MD 21701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar F. H. TCHD 8 H broneD Certificate of Death Pha 9/27/11 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2038 PM Marrise Dotson Medical Examiner 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death County of Death ambrid nchester lorche. a If Under 1 Year If Under 24 Hrs **Funeral** Birthplace (State or Foreign Country) Date of Birth 1 🗆 M 2 🔀 F Months Days Hours Min (Month, Day, Director Vland Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c, City, Town or Location Director 10d. Inside City Limits be notified 1 Yes 2 No OC 0 10e. Street and Number 10g. Citizen of What Country? Funeral "natural", or items 23a Examiner must 21643 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ò 1 Never Married 2 Married Baltimore, Maryland 21245-0036 1 ☐ Yes 2 🛣 No 3 Widowed 4 Divorced Completed Specify: Black ed other than "natur event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry
Colonel Richardson (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Hygiene. 1 L Schoo mit. Page 1 and 2 should be filed wit bartment of Health and Mental Hygie outant; If item 27 is marked other injury or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Holden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Allen - Daughte P.O. BOX Jeanette Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🗷 Burial 2 🗌 Cremation 3 🗌 Removal from State Washington 4 Donation 5 Other (Specify) 09-29-2011 Hurlock, Md Signature Funeral Service Licensee Name and Address of Facility Bennie Smith Fun 516 S. main Street Funeral Hame Mary land Hurlock 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph sician/ Onset and Death ongestive Heart disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Year signed by the a Yes 2 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an s certificate has the director, page 2 s autopsy
performed?

1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 1 Tes 2 No Other: 1 Ninpatient 2 ER/Outpatient 3 DOA 24 hours after death.

Funeral Director: After this leted filled in by the funeral dil 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the 29b. Signature and title of certifier 29c. License number D65528 po Ahmed 122 2011 Labib 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ahmed Labib MD , 300 Byrn S Ahmed MD 21613 31. Date filed (Month, Da Registrar's Signa State Registrar

Registrar

1 sacras

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 32948 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 09 2011 Roosevelt Ellerbe 5:30a Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 2818 63rd Place Cheverly Prince George's . Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 6 Sex 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign 8. Date of Birth Days 1 XM 2 | F Hours Min 08/05/1949 Washington. **Director** 62 578-66-4587 Usual Residence of Decedent 28a-f show 10a State Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Prince George's Cheverly 1 X Yes 2 No 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 2818 63rd Place 20785 USA items death 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc "natural", or þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 72 hours after Yes 1 ☐ Yes 2 XNo Specify: Specify: Black 3 Widowed 4 Divorced If Yes, Give Completed Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Steam Engineer Government 8th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Jackson Ellerbe, Sr. Maggie Ellerbe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sl tment of Health a tant: If item 27 is Diane Ellerbe/Wife 2818 63rd Place Cheverly, MD 20785 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of H Important: If ite 20c. Location - City or Town, State 9 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place, injury o Harmony Memorial Park 9/30/11 Landover, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Marshall-March Funeral Home 4308 Suitland Road Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph_sician SEPS15 disease or condition Medical resulting in death) Due to or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Incular Disease Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events and -tran Due to (or as a consequence of) resulting in death) Last burialthe attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 thet detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Pregnant at time of death Day Year 2 No 9 Unknown Unknown been signed by should be detact Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital ျှ 1 Tyes Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director, After completed filled in by the funer Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. The deficial Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and fitte 29d. Date signed (Month, Day, Year) ho completed cause of death (Item 23a) (Type, Print) State OCT O

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Carey P Flynn		Sta 1- For State Registrar	ate of Maryla		artment o		Mental H	_	201	1 32949
Physic Medical Exam		Carey Patr	ick Flyn					2. Date of Deat Month October 6	Day Year , 2011	3. Time of Death 0554 hrs
		4a. Facility Name (if not institution, give street and number) Atlantic General Hospital 4b. City, Town, or Location of Death Worcester								
Funera				7. Age (In yrs. la	ast birthday)	If Under 1 Year	If Under 24Hrs	. 8. Date of Bir	th(MM/DD/YYYY)	9. Birthplace (State or
Directo		577-64-0218	1 M 2 F	63	Yrs	Months Days	Hours Min.	1/2/1	1948	Foreign F¹L
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P 49			ester							10d. Inside City Limits 1 X Yes 2 No
daryland 28a-f show any Lat once,	cto	10e. Street and Number	ester	1 00	cean C	10f. Zip Code		10	Og. Citizen of What	
ith the Maryland 23a or 28a-f sho notified at once.	ğ	10249 Broken	Sound B	lvd.		21842			USA	
h with	Funeral Director	11. Marital Status	12. Was Dece	dent Ever in U.	S. 13. Wa	s Decedent of Hispa es, specify Cuban, N	anic Origin? (Sp	ecify Yes or No-		American Indian, Black,
er deat	Ę	1 Never Married 2 Mar 3 Widowed 4 Divo	1 Yes	2 X No				rican, etc.)		
urs aft tural"	d by	15. Decedent's Education (Speci	or Dates:	completed)		Yes 2 X No		vork done	Specify: 16b. Kind of Busin	White ness/Industry
6 72 bo	Completed	Elementary/Secondary (0-12)	College (1-		during m	ost of working life. D	O NOT use retir	red)		•
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21215-0036 und be filed within 7 Mental Hygiene. marked other than	Be C	17. Father's Name (First, Middle, I Robert Flyn	*				.Mother's Name 「ean Ca		faiden Surname)	
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she curatic event, the Medical Examiner must be notified at once	10 E	19a. Informant's Name/Relationshi		-	19b. Mailing	Address (Street a			ber, City or Town,	State, Zip Code)
- 명취 등록		Beverly Fly	ynn / wi							city, MD
		20a. Method of Disposition 1 X Burial 2 Cremation	3 Removal from	n State C	rematory or oth		- "	Date	20c. Location - Ci	
Baltimo permit. Pages Department or Important: I		4 Donation 5 Other Soc 21. Signature of Funeral Societies	ecify:	Gat		Heaven C	E 100			
Balt permit Depart Impor Injury		21. Signature out therail scrope L	Icensee			ame and Address of 8 Willia	BU		Funeral	
Physician		23a (Part I. Enter the disease, or ca failure. List only one cause o	omplications that cau	ised the death.	Do not enter th	e mode of dying, su	ch as cardiac or	respiratory arre	st, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a Abdomina							Death
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	iner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a c	onsequence of)):					
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iO, e be executed ysician and burial - transit	edical	X UNPENDED	AMENDED 2	3a,pt.]	[1,27,2	8a-f,per	me,g922	12-2-1	1 sm	
760, icate b physic the bur		IF FEMALE: 23b. Was decedent pregnant in the	P	tcome of pregn	ancy		_		23d. Date of del	livery
Box 6876(death certificate the attending physical for use as the b	cian	past 12 months?	1 Live birt	h it at time of dea	Ale -	al death 3 er (S <i>pecify)</i>	Ectopic pregnar	ncy	Month	Day Year
BOy e death the att	Physician/M	1 Yes 2 No 9 Unkno	9 Unknow						1	
P.O. is that the gned by e detach	by P	Part II. Other significant condition								e to the cause of death?
ds, P.C quires that en signed ald be deta		Obesity with h	nistory of	gastri	ic blee	ding;hype	<u>rtensi</u> v	e 1 Yes		Probably 4 Unknown
COFC law re has be	Completed	<u>cardiovascular</u>	disease:	congeni	tal he	art block	;	autops	y prior	e autopsy findings available to completion of cause of th?
tal Recian: The certificate ector, page		cirrhosis of t	he liver			26 Place of	Death (Check o	1 Y Yes 2		Yes 2 No
Vita ysician ysician directe	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inp	atient 2 🗸 E	R/Outpatient		or —		Residence 6 C	Other:
I Of I	-1	27. Manner of Death	28a. Date of (Month, Date	Injury ay,Year)	28b. Time of In	ury 28c. Injury a			ow injury occurred	-
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Division of Vital Records, P.O. Box 6876. the Hospital or Attending Physician: The law requires that the death certificate hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending phy piletely filled in by the funeral director, page 2 should be detached for use as the t	Certification:	3 Suicide 6 Could r	lot be		ne, farm, street ts Bar	, factory, office build			reet and Number of ate) 12702 0	r Rural Route Number, City
the Hospital hin 24 hours. the Funeral		20a Cartifiar	sician: To the best o			ed at the time, date a		Rout 707 due to the cause		City,Md.
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Exami	ner:On the basis of e	examination and	d/or investigation	on, in my opinion, de	eath occurred at	the time, date a	nd place, and due t	to the cause(s)
	Σ	29b. Signature and title of certifier				29c. License nu			29d. Date signed	
		1114 -			219	O.C.M.E	=,		October 7, 20	11
		 Name and address of person when Russell Alexander MD. 	no completed cause of Assistant Med	Section 1	,	V. Baltimore St	reet, Baltimo	ore, MD 212	23	
		31. Date filed (Month, Day, Year)		strar's Signature	9, ,					
Regist	rar	<u>0</u> CT 11	2011 Ben	was p	1. pac	Kal	-	OCME		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. The Phy G920 10/24/2011 State of Maryland / Department of Health and Mental Hygiene ()

State Certificate of Death Registrar 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ SEPT. SHIRLEY MAE FRYE 27 2011 6:33 44 P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 4501-R- Talcott Terrace Perry Hall Baltimore 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last hirthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Months Days Min 1 🗆 M 2 💢 F NOV. 28, Maryland Director 215-26-1671 81 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturo" any finury or other traumatic events any finury or other traumatic events. 10b County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Perry Hall 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 4501 R-Talcott Terrace 21128 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ģ 1 Never Married 2 X Married 1 ☐ Yes 2 ▼ No Specify: Completed 3 Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Education Elementary/Seconday (0-12) College (1-4 or 5+) + School Vice Principle School Board Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John Foster Edna Deaner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles W. Frye / spouse 4501-R- Talcott Terrace/ Perry Hall, MD 21128 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory 09/30/2011 Frederick, Maryland 21. Signature of Funeral Service Licer 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike/Frederick, MD 21702 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death D_[1]sician/ andlac Medical Due to (or as a consequence of): Examiner disease car1 60 ronari Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of Cause (Disease or iinjury that initiated events resulting in death) Last igned by the attending physician and be detached for use as the burial-trar Due to (or as a consequence of) Physician/Medical the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death

9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 12 mo in the past 12 Month Dav Year Vas 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>≽</u> mellitus Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 No After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending (Month, Day, Year) Natural 5 Pending injury death 1 Yes 2 No М Accident Investigation Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Spec/fy) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) after determined 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier pleted (Check within 2 To the 1 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of cg 29c. License number 29d. Date signed (Month, Day, Year) 11 D00 47 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 Bayview Circle, Baltimore, MD 21224 D UMO mo DAMVE 5505 Hopkins 31. Date filed (Mont) Registrar's Signatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death I, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 27, Physician/ Month Laurel George Feldt 2011 00:47hrsM S<u>eptember</u> Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Gaithersburg Montgomery 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs 8. Date of Birth Birthpia Country) IL 1 M 2 □ F Hours 01/26/1923 Director 343-12-1959 88 Usual Residence of Decedent 10a. State 10b. County the Maryland 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f MD 1 Yes 2 No Frederick Monrovia 10e, Street and Number ö 10f. Zip Code 10g. Citizen of What Country? be Funeral with 1 23a must 3724 Blueberry Drive 21770 death n "natural", or item ledical Examiner n 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Black. White, etc. þ 1 Never Married 2 X Married 1 X Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 and 2 should be filed within 72 hours after 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced Year or Dates. 1941-93 White other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 10 Supervisor Foreman Be 17. Father's Name (First, Middle, Last) and Mental F 18. Mother's Name (First, Middle, Malden Surname) မ George Bernard Feldt unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health a Velma Feldt/wife 3724 Blueberry Drive, Monrovia, MD 21770 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or o 1 Magnetic Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place. Mt. Olivet 10/01/2011 Frederick, MD Sign ture of Funeral Service License 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease, or complications that caused shock, or hear failure List only one cause on each line ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final 9 2two Onset and Death h, sician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner holangiti Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury docho chole that initiated events resulting in death) Last Due to (or as a consequence of) ng physician ar as the burial-t Physician/Medical requires that the death certificate be P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year 1 ☐ Yes 2 L 9 ☐ Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Dulmonzy embol Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown technicardia Were autopsy findings available prior to completion of cause of death? ventricular Hospital or Attending Physician: The law cate has page 2 s autopsy Sleep perform appea this certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No Division of Vital 25. Was case re erred to medica Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☑ No Other: ျ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Mann of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes ☐ Accident Investigation 2 🗌 No within 24 hours after deatl To the Funeral Director. completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the basis of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of confier 29d. Date signed (Month, Day, Year) Sept 27 -011 ited cause of death (Item 23a) (Type, Prin 30. Name and address of person $\mathcal{S}_{\lambda_{J}}$ Russell Ave. Gaithersburg MO 31. Date filed (Month Pay e trar's Signature State Registrar

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			1 - For State of Maryland / Depa		lental Hygie	•	32952
	Physicia		1. Decedent's Name (First, Middle, Last)	modic of bodin	2. Date of Death	e ^{Pey} 23, ^Y 2º01	3. Time of Death
	Medi Examir			4b. City, Town, or Location of Death Gaithersburg			
	Funeral Director	Г	5. Social Security Number 6. Sex 7. Age (<i>In yrs. last birthday</i>) 1	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth	9. Birth	place (State or Foreign
yland	-f show ed at	içi	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Local				10d. Inside City Limits
h the Mar	a or 28a- be notifi	al Director		10f. Zip Code		g. Citizen of What Cou	
death wit	items 23 ner must	Funeral		as Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto	cify Yes or No-	United Sta	can Indian,
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1215- thin 72 ho	than "na the Medic	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kin life. DO 12 College (1-4 or 5+) Book	nt's Usual Occupation nd of work done during most of work! NOT use retired) keeper	ng	6b. Kind of Business Ir Private	dustry
Baltimore, Maryland 21215-0036	Department of Health and Mential Hygene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be (17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Maid Blackman	_	- -
Maryl 2 should	th and Me 27 is marl traumati		19a. Informant's Name/Relationship (Type, Print) Jeffrey Gelfand – son 19629	Address (Street and Number or Rura Ridge Heights Di	Route Number Cit Cive Gait	ty or Town, State, Zip, hersburg "Y	D ^{del} 20879
nore,	t: If item		20a. Method of Disposition 1 Burial 2 Acremation 3 Removal from State 4 Donation 5 Other (Specific) 1 Removal from State National	tion (Name of tory or other place)		c. Location - City or To	
Baltir permit. Per	Deparme Importan any injury once,		4 El Boliation 3 El Other (Specify)	Name and Address of Facility nzansky-Goldberg II/O Rockville			·
			23a Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.			Ville MD 2	Approximate Interval Between
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5 be executed	ician a d burial- lan	ical Exa	that initiated events resulting in death) Last C				
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VItal Kecords, ysician: The law requires	200	Completed			24a. Was an autopsy performed	24b. Were auto	psy findings available mpletion of cause of
tal π cian; Th	s certificate has be lirector, page 2 s		25. Was case referred to medical examiner?	26. Place of Death (Check	1 Yes 2		2 No
OT VI	er this o	e: To	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 27. Manner of Death 28a. Date of injury 28b. Time of		ne 5 Residence	e 6 Other (Specify)
DIVISION tal or Attendin rs after death.	ector: Aft by the fur	Certificate:	1 Matural 5 Pending (Month, Day, Year) Injury 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At home, farm, street	M 1 Yes 2 No		t and Number or Rural	Route Number
DIVISION OF VITAI REC To the Hospital or Attending Physician; The la within 24 hours after death.	neral Dir	Medical Ce	29a. Certifier 1 Certifying Physician; To the best of my knowledge, death occ	sured at the time, date and place, and	City or Town, St	tate)	d
o the Ho	o the Fu omplete		(Check 2 Medical Examiner: On the basis of examination and/or investigationly one) 3 Certifying Nurse Practioner: To the best of my knowledge, deal 29b. Signature and sittle of certifier	ation in my opinion death occurred at	the time, date and ple, and due to the cau	lace, and due to the ca use(s) and manner as st	use(s) and manner stated. ated.
	20		Delgabeth Kin Nurse Practitione	R139631	29d.	Date signed (Month, $\frac{1}{2}$)	20 //
			30. Name and address of person who completed cause of death (Item 23a) (Type, Prin Elizabeth A. Kim, CRNP 301 Russell Aver	nue; Gaithersburg	, MD 208	877	
R	State Registra	e r	31. Date filed (Month, Day, Year) SEP 3 0 2011 32. Pégistrar's Signature	and.			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra MEND#19 openFH, 10/4/11; BMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 09726/2011 3:10P Margery Colding Gordon Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Wilson Health Care Center Gaithersburg 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral 1 □ M 2 🗓 F Months Days Hours 0472371919 New York 92 Director 578 26 3450 Usual Residence of Decedent items 23a or 28a-f shov her must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County filed within 72 hours after death with the Maryland Director MD Gaithersburg Montgomery 1 YYes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral 20877 United States 301 Russell Ave. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Deceue... Armed Forces? Ves 2 No 12. Was Decedent Ever in U.S. ural", or iten I Examiner n 11. Marital Status 14. Race - American Indian. Black, White, etc. Completed by 1 X Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify: "natural", 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Department Store 12 Sales Associate e 1 and 2 should be filed wit of Health and Mental Hygie If item 27 is marked other in other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Edna Colding Adam Rolla Gordon 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Poolesville, MD 20837 <u>Elizabeth D. Gordon/Niece</u> 2 Christer Street 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Page 1 a Department of H Important; If ite any injury or ot 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 11/03/2011 Washington, DC Rock Creek Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility Joseph Gawler's Sons, Inc. 21. Signature of Fune Service License 20016 Washington, DC 5130 Wisconsin Ave., NW 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Let only one cause on each line. Onset and Death Immediate Cause (Final Physiciani Sciondarite advanced disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Seminated list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) ate has been signed by the attending physician and page 2 should be detached for use as the burial-trinsit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-trifingt that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Day Year Pregnant at time of death 1 ☐ tes 2 € 9 ☐ Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 🗌 Yes 2 🗌 No 3 🔲 Probably 4 🗹 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 2 No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No injury Natural 5 Pending Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature at 15 Murse Prachhoner

Registrar
DHMH 17 Rev 7/2009

State

Elizabeth Kim/Nurse Practitioner 201 Russell Ave. Gaithersburg, MD

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

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11-07224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Marisol Gutierrez	Sta 1- For State Registrar	ate of Maryland		ent of He		Mental F		20	32954
Physician Medical Examine	1. Decedent's Name (First, Middle,Last)						2. Date of Dea	eg. No. th Day Year er 25, 2011	3. Time of Death 0438 hrs
	4a. Facility Name (if not institution Columbia Pike at Tech	n, give street and numbe		4b. Ci		ocation of Deat		4c. County of Montgom	
Funeral Director	5. Social Security Number 230-37-1659	6. Sex 7. A	ge (In yrs. last birt 29	thday) If (Under 1 Year onths Days	If Under 24Hr Hours Min		th(MM/DD/YYYY)	9. Birthplace (State or Foreign Washington, Country)
Aaryland 28a-f show any 1 at once.	Usual Residence of Decedent 10a. State 10b. County VA Princ	ce William	10c. City, Town Woodbr						10d. Inside City Limits 1 Yes 2 X No
5-0036 ed within 72 hours after death with the Niygiene. uther than "natural", ur items 23a nr the Medical Examiner must be notified	11. Marital Status 1 Never Married 2 Ma 3 Widowed 4 Divo 15. Decedent's Education (Spec Elementary/Secondary (0-12) 17. Father's Name (First, Middle,	1 Yes 1	9? 2 X No empleted) 16a. (13. Was Dec If Yes, sp 1X Yes Decedent's Us	ecify Cuban, M 2 No ual Occupation working life. D	Mexican, Puerto specify: Bol n (Give kind of 10 NOT use ref	pecify Yes or No o Rican, etc.) ivian work done ired)	U. S. A. 14. Race - White, Specify: W 16b. Kind of Busi Landsca	American Indian, Black, etc. hite ness/Industry
MD 2 shoul salth and N em 27 is or raumatic		ip(Type, Print) Cez – Sister	20b. Place o		ess (Street a senhower Name of ceme	ond Number or Circle,		nber, City or Town, odbridge, V	
Baltimore, permit. Pages I ar Department of Hee Impurtant: If ite injury ar ather tr	4 Donation 5 Other Sp. 21. Signature of Funeral Service I	ecify:	.u.o	al Memor	ial Park and Address o	Facility	7482 Lee		Church, VA 22042 alls Church, VA
Physician /Medical ≜xaminer	23a. Part I. Enter the disease of failure. List only one cause of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	omplications that cause	d the death. Do no	t enter the mod	de of dying, su	ch as cardiac	or respiratory arre	est, shock, or hear	Approximate Interval Between Onset and Death
be excended sician and untal - fransit edical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons Due to (or as a cons d.							
lox 68760, leath certificate by a strending physic for use as the burnsician/Mec		4 Pregnant a	me of pregnancy t time of death 5	Fetal dea		Ectopic pregna	ancy	23d. Date of de Month	elivery Day Year
IS, P.O. Equires that the densigned by the detached lid be detached the Dy Phy		ens contributing to dear	th but not resulting	in the underly	ing cause give	en in Part I.	1 Yes	2 ✔ No 3	te to the cause of death?
tal Records, cian: The law require certificate has been signer. The page 2 should be Be Completed	25. Was case referred to medical				26 Place of	Death (Check	24a. Was a autop: perfor	sy prid med? dea	ere autopsy findings available or to completion of cause of ath? Yes 2 No
Division of Vital lat or Attending Physician. Is after death. al Director: After this certied in by the funeral director artification: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendir	28a. Date of Inju	ury 28b. T	tpatient 3 ime of Injury	DOA Oth	ner Nursir	ng Home 5 28d. Describe h	Residence 6 🗹 now injury occurred n an auto to a	
Division o Ta the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune-		not be inned (Specify) Ma	njury - At home, far ajor Road / Hig	hway	ory, office build	ding, etc.	or Town, Si Columbia Pike	ate) at Tech Road,	or Rural Route Number, City Silver Spring, MD
Tn the Howithin 24 h To the Fun completely	(Check only 1 Certifying Phy	siclan: To the best of m Iner:On the basis of exa and manner stated	ny knowledge, deal mination and/or in	vestigation, in	my opinion, de	eath occurred a	I due to the cause at the time, date a	and place, and due	to the cause(s)
10	Family Cuthar 30. Name and address of person w	(), M)	leath (Item 23a)		O.C.M.			September 2	(Month, Day, Year) 25, 2011
11	Pamela E. Southall, MD	Assistant Med	ical Examiner			Street, Balti	more, MD 21	223	
State Registra	31. Date filed (Month, Day, Year) SEP 3 0	2011 Sener	r's Signatur	gara					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 32955 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death September Day 0,2011 2:15 am M Josefina A. Giner Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Bethesda Suburban Hospital 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 Ty Hours Min. J#19731 Months 80 Director 581-11-0896 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location must be notified at be filed within 72 hours after death with the Maryland Director Silver Spring Montgomery 1 Yes 2 XNo 10f. Zip Code 10g. Citizen of What Country? ō 10e. Street and Number 12913 Hawkshead Terrace USA 20904 items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian. Medical Examiner Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 5 Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 XYes 2 No Specify. Cuban If Yes, Give Year or Dates Specify: White "natural", 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) h and Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Home Maker other traumatic event, Be 18. Mother's Name (Eirst, Middle, Maiden Surname) Josefina Llagostera 17. Father's Name (First, Middle, Last) Manuel Azcona 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Maria E. Reed/Daughter 12913 Hawkshead Terrace Silver Spring, MD 20904 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 26F1 Alexandria, Virginia Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Licensee Francis J. Collins Funeral Home Inc. Michard 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ACUTE RENAL FAILURE disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner CONGESTIVE HEART PAILURE TEARS Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events TEARS CHNONIC RENAL FAILURE attending physician and I for use as the burial transit Due to (or as a consequence of): resulting in death) Last TEHNS DIABETES MELLITUS Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: Sept 20, 2011 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? sate has been signed by the a page 2 should be detached 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPENITUSION, UNESITY PULMONARY 1 Yes 2 No 3 Probably 4 Unknown JEPSIS CELLULUTIS AWEMIA 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate by 1 ☐ Yes 2 ☐ No Yes 2 No SINER, VOSEFINA empleted filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 \(\sum \) Yes 2 \(\sum \) No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ျပ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) REPTENDEN 30, 2011 D29256 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

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Registrar

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31. Date filed (Month, Day, Year

OCT 03 2011

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Registrar's Signature

8600 OLD GEORGETOWN PD , BETHESDA MO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 3<u>0 201</u> Month Michael D. Gilley September 3:15 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Woodbine Howard 14827 Old Frederick Road Social Security Numbe If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) Days Min. 218-46-8695 **Director** 1**X** M 2 □ F 62 Usual Residence of Decedent Dec 14, 1948 Maryland show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State must be notified at 10b. County 10c. City, Town or Location Director 1 Yes 2 X No MD Woodbine Howard 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 14827 Old Frederick Road 21797 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) item 27 is marked other than "natural", or iten other traumatic event, the Medical Examiner 14. Race - American Indian Black, White, etc. ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Specify: White Completed Year or Dates 969-70 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Graphic Artist/CFO To You Graphics Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) 2 James Layton Gilley Mary Helen Wardell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cyndy Gilley/wife 14827 Old Frederick Road Woodbine, Maryland 21797 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place. 4 Donation 5 Other (Specify) Cremation Svc 10/01/2011 Hanover, MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc uante 4112 Old Columbia Pike Ellicott City, MD 21043 Homas 23a. Part) Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final 0 Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Pregnant at time of death 5 Other (specify) Dav Year signed by the a 1 Yes 2 L 9 Unknown 9 | Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown certificate has been si lirector, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospita Other: ျ 1 Yes ≥√Z No 1 Inpatient 2 I ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 24 hours after death. Funeral Director: A 1 🗌 Yes Accident Investigation the Suicide Could not be filled in by 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely within 2 To the I only one 29b. Signature a Chitit 29d. Date signed (Month, Day, Year) 12006317 Md 30. Name and address of person who completed cause of death (Item 23a) (Type, Print

DHMH 17 Rev 06-2011

State Registrar axn

31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 Judy Ann Marie Giachino October 4:15 \mathbf{g} Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 5112 Bonnie Branch Road Ellicott City Howard Social Security Number 7. Age (In yrs. last birthday) 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** If Under Days Hours 215-52-3310 **Director** 1 □ M 2 🕱 F 65 Yrs MD Usual Residence of Decedent 04/04/1946 28a-f show 10a. State with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits notified 1 🗌 Yes 2 🔀 No MD Howard Ellicott City 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral must be 23a 5112 Bonnie Branch Road 21043 United States items ? Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items ı "natural", or iten ledical Examiner r 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. Specify: Completed 3 Widowed 4 Divorced White er than "natur, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) ulth and Mental Hygien 27 is marked other the r traumatic event, the Activities Coordinator Nursing Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ John Lawrence Wessel Anna Dorothy Foschia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Dominic P. Giachino - husband 5112 Bonnie Branch Road Ellicott City, MD 21043 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10/05/2011 Paul's Luth. Cem. Fulton, MD Signature of Funeral Service Licens 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc 4112 Old Columbia Pike Ellicott City, 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ ONGESTIVE 4ENRT disease or condition Medical resulting in death) Examiner ALVULAR Sequentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): use s the burial-transit and Due to (or as a consequence of): resulting in death) Last physician Physician/Medical The law requires that the death certificate be Box 68760 a endin-IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 month Month Day Year Pregnant at time of death Unknown be detached the 9 Unknown P.0 signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use stribute to the cause of death? þ Division of Vital Records, 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed should Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy performe death? certificate 1 🗌 Yes 2 🗌 No 2 Yes the Hospital or Attending Physician: funeral director, 25. Was case referred to nedical Be 26. Place of Death (Check only one) examiner? Hospita Other ပ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) this 27. Manne Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury Certificate: 28c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director; After atural 5 Pending 1 Yes 2 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check within 2. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year)

State Registrar

OCT 0 3 201

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Name and addless of person who completed cause of death (Item 23a) (Type, Print)

Ingistrar's Signature for Spark

Wilkers Arc.

32. Registrar's Signature Date filed (Month, Day, Year) State Registrar

Victor Weedn MD JD

30. Name and address of person who completed cause of death (Item 23a)

Weeks

Assistant Medical Examiner

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 9/14/2011 Physician/ 4:15p M MARY HARDING Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Washington Adventist Hospital Takoma Park If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 80 Min. MD Country) 1 M 2X Months Days Hours 6/28/31 Director 579-38-4625 Usual Residence of Deceden 28a-f show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if item 27 is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic event, the Medical Examiner must be notified at any highry or other traumatic event, the Medical Examiner must be notified at any bines. 10a. State 10b. County 10c. City, Town or Location Director 1 😾 Yes 2 🗌 No Prince Georges College Park 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral U.S.A 20740 4711 Berwyn House Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. ☐ Yes 2 🕱 No þ 1 Never Married 2 Married ltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify 3 Widowed 4 Divorced Completed Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Research Svc. Government 8th Agricultural Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) P Charles LeRay Hamlett Eva Brooks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3117 Parkway Drive, Cheverly, MD 20785 Cynthia Harding / daughter 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Nat'l Mem.Park 9/28/2011 Laurel, MD 4 Dopation 5 Other (Specify) Md. 21. Signatur Funeral Service Lic Snowden Funeral Home N.Washington St., Rockville, MD 20850 23a. Part 1. Enter the disease, or com-shock, or heart failure. List only nications that caused the death. ne cause on each line. Approximate Interval Between Onset and Death of enter the mode of dying, such as cardiac or respiratory arrest. Immediate Cause (Final Physician/ thetoscleratic COTOMANY disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence or). signed by the attending physician and d be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be exect 24 hours after death. resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 1 ☐ Yes 2 ≥ 9 ☐ Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ٤ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a, Was an has death? this certificate Yes 1 Yes in 24 hours after death.

the Funeral Director: After this certifical pleted filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) work?
1 Yes 2 No 5 Pending M 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 To the I 29b. Signature and title of certific

Registrar
DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

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SEP 30

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month 2250 M 20 Year SEP Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** old ask akoma 30 327 62 8 Date of Birth (Month, Day, If Under 1 Year If Under 24 Hrs. Sex 1 XM 2 □ F 7. Age (In yrs. last birthday Birthplace (State or Foreign **Funeral** Director iral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director MD 1 X Yes 2 No HDELPHI GEORGES 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8402 RAMBLÉR 20783 USA DR 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ģ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Ho Specify. Completed 3 Widowed 4 X Divorced BLACK Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 MAINTENANCE PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ CARRINGTON DAVID MARGARET 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SILVER SPRING DAISY G. HOSTEN-HOLNESS-DAUGHTER 1330 CHILTON MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) CEMETERY CATEOF HEAVEN OCT. SILVER SPRING 6 2011 21. Sign 💯 👓 🗸 Funeral Service Licerse 1425 MARYLAND AVE NE WASHINGTON DC 20002 MORTUARY 23a. Part 1. Enter the disease shock, or heart failure. U or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, st only one cause on each line. Interval Between Immediate Cause (Final Kin Onset and Death Physician cho disease or condition Medical mD resulting in death) Due to (or as a consequent of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of): TO THE the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the atter completed filled in by the funeral director, page 2 should be detached for u in the past 12 months? Tyes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? Yes 2 N 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: ြု 1 Inpatient 2 ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injur 1 Accident 5 Pending work? 1 ☐ Yes 2 ☑ No 9/25/2011 9:55 Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 8402 Kambler Or, Adelah 28e. Place of Injury - At home, farm, street, factory, office etc. (Specify) determined building, etc. Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific ĬD 69081 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Brian G. Tenney, (a 31. Date filed (Month, Day, Year, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death . 2011 Physician/ Month 30 4:30 A^M Sept. <u>Cordelia M. Holmes</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Fort washington Prince Georges 7617 Bock Road 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Ye 6. Sex 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Months Days Hours 938 Director 226-44-9098 Auq. Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director 1 ☐ Yes 2 √ No MD Fort Washington Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 7617 Bock Road 20744 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No þ 1 Never Married 2 X Married 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: Black If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Teacher Health DCPS - Education Elementary/Seconday (0-12) College (1-4 or 5+) d Mental Hygiene. marked other tha 5+ Physical Education & Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Sarah Coleman Charles Humphrey Michie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other tra Ernest Holmes - husband 7617 Bock Road, Fort Washington, MD 20744 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Lincoln Memorial Cem. 10/7/2011 Suitland, MD 4 Donation 5 Other (Specify) 21. Signature of Fundral Service Licer 22. Name and Address of Facility J. K. Johnson Funeral Home, PA 6503 Old Branch Ave., Temple Hills, MD 20748 rt 1. Enter the disease, or com ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Part 1. Enter the disease, or constock, or heart failure. List only Approximate Interval Between ause on each line Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Carcinoma of Lungs vears Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) requires that the death certificate be executed Cause (Disease or liniury burial-tra that initiated events resulting in death) Last Due to (or as a consequence of) ng physician a Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? for Month Year Day Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🙀 No 9 ☐ Unknown the 9 Unknown þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law is within 24 hours after death.

To the Funeral Director: After this certificate has E completed filled in by the funeral director, page 2 si autopsy performed?

1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5X Residence 6 \square Other (Specify, 2 🔀 No 1 Tyes ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 Yes Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Aural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29a. Certifier (Check

only one 29b. Signature and title

30. Name and address of person w

William R. Frederick, M. D. 106 Irving St., NW, Suite 304, Washington, DC 20010 31. Date filed (Month, Day, Year 32. Registrar's Signature OCT 0 4

completed cause of death (Item 23a) (Type, Print)

certifier

Ceptifying Murse Fractioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

4502

29c. License number

29d. Date signed (Month, Day, Year)

October 3, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 9-26-2011 8:45 P Ruth D. Hopfer 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Talbot William Hill Gardens Easton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12-22-1923 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days Hours Min 1 ☐ M 2 💢 F NJ 146-14-3114 87 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Talbot Easton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 545 Cynwood Drive 21601 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐Yes 2X No Specify: Specify.White 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edith Eggerking Robert Darke 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10551 Todd's Corner Rd Easton MD 21601 Donald E. Webster (son) 20b. Place of Disposition (Name of cemetery, crematory or other place).
Chesapeake Cremation 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 9-27-2011 Stevensville, MD Center 21. Signature of Funeral Service Licensee Fellows, Helfenbein & Newnam Funeral Home P.A. TI WHOIR 200 S. Harrison St Easton MD 21601 MERCER Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) End struct Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No

Physician /Medical Examiner Completed by Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed

Physician

/Medical

Examiner

10a. State

MD

Funeral

Director

ral", or items 23a or 28a-f show Examirer must be notified at

"natural", er than "natura", the Medical I Director

Funeral

Completed by

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filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

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permit. Pages 1
Department of H
Important: If Iter
any injury or ott

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and ending physician a use as the burialfor should be detached signed by page 2 s Jas certificate after death.

Director: After this certific d in by the funeral director,

Certification: To Be

Medical

29a. Certifier

filled in by

within 24 hours a

Division of Vital Records, P.O. Box 68760,

IF FEMALI	E:
in the 1 □Y	decedent pregnant past 12 months? es 2 \times\text{Vo} Inknown

art II.	. Other significant conditions contributing to death	but not resulting in	the underlying cause of	jiven in Part I.
14	reentension			

	1 🗀 103
	24a. Was an autopsy performe
26. Place of Death (C	Check only one,
	26. Place of Death (C

							1 - 100 -	
25. Was case referred to medical					26.	Place of Dea	th (Check only one)	
examiner? 1 ☐ Yes 2 XNo	F	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient	3 🗆 D0	OA Other: 4	☐ Nursing H	ome 5 Residence	6 Nother (Specify) Asst. Liv
	Pending nvestigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	M 2	28c. Injury at Work? 1 □ Yes	2 🗆 No	28d. Describe how inju	ary occurred
	Could not be	28e. Place of Injury - At ho	ome, farm, stree	t, factor	y, office		28f. Location (Street a	and Number or Rural Route Number,

3 Suicide 4 Homicide	6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, offi building, etc. (Specify)
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dotominod	building, etc. (Specify)	City or Town, State)					
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
2 Medical Examine	er: On the basis of examination and/or investigation, in my opinion, death occ	curred at the time, date and place, and due to the cause(s)					

te signed (Month, Day, Year)

one)	30 CHOP	and manner stated.
29b. Signature	e and title of certifier	
1 3/2	H 6. Show	- CRNP

29c. License number	29d. Date signed (Month
RO77623	9-27-11

21601

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Easton 545



State Registrar

5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ SEPT. LISA 2011 10:06 PM **JENKINS** Μ. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death SOUTHERN MARYLAND HOSPITAL CLINTON PRINCE GEORGES 6. Sex Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Hours JUNE 2, SOUTH CAROLINA Director 251-19-3480 1964 47 Usual Residence of Decedent 28a-f show than "natural", or items 23a or 28a-f sho he Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No PRINCE GEORGES CAPITOL HEIGHTS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1219 BALBOA AVE. 20743 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force 0. Black. White, etc. Completed by 1 Yes 2 If Yes, Give Year or Dates. 1 X Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: 3 🗌 Widowed 4 🗆 Divorced Specify: BLACK injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 NEVER WORKED NONE is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) UNK. ಲ HATTIE Μ. **JENKINS** 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1495 TRINITY DR., SHERMAN JENKINS/SON COLUMBIA, SC. 29209 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 9-28-2011 CHAMBERS CREMATORY RIVERDALE, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
CHAMBERS FUNERAL HOME & CREMATORIUM, P.A roundless M00091 5801 CLEVELAND AVE., RIVERDALE, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Alcoholic disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury as a consequence of: transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): burial-Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy Month Pregnant at time of death Dav Year 9 Unknown Hospital or Attending Physician: The law requires that the signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 2 No Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 I 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After Natural 5 Pending Accident 1 Yes 2 No Investigation the Suicide Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signatu

State Registrar DHMH 17 Rev 7/2009

Box 68760

Records,

Division of Vital

ss of person who completed cause of death (Item 23a) (Type, Print) 2700

Todenate

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 Year Sept. Roger Hicks Jones 11:50 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Chesapeake Woods Center Dorchester Cambridge If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday, Funeral 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 □ F March 2, 1922 Maryland Director 218-09-9161 89 Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director Maryland | Dorchester 1 🗌 Yes 2 🔯 No Hurlock 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4403 Cabin Creek Road 21643 USA Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, White, etc. Armed Forces? 1942 If Yes, specify Cuban, Mexican, Puerto Rican, etc.) þ 1 Never Married 2 Married 1 X Yes 2 □ No If Yes. Give 1 ☐ Yes 2 X No Specify: 1945 Completed 3 X Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Carpenter Home Improvement Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked Orrie H. Jones Hattie Mae Wheatley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terry Nuwer/Neighbor 4407 Cabin Creek Road, Hurlock, Maryland 21643 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place, 5 Other (Specify) 4 Donation Crematory of Delmarva 9/28/2011 Delmar, Delaware Zeller Funeral Home, P. O. Box 207 106 Main Street, East New Market, MD 21631 Part 1 Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ COPD disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner PULMONARY FIBROSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) that the death certificate be executed and bunial-trar Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical IF FEMALE nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Pregnant at time of death Dav be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform certificate Yes 2 N 1 Yes To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Hospital Other: 2 No ٩ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 P Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural
Accide 5 Pending work? 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD D69234 27 and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Division of Vital Records.

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CAMBRIDGE

STREET

21613.

MD

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DHMH 17 Rev 06-2011

State Registrar Sadaf Taimur, M.D.

31. Date filed (Month, Day,

egistrar's Signature

46B Thomas Johnson Drive, Frederick, Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Sept. 28, Day 2011 Paul Golden Leary 5:34 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4133 Whiteleyville Road Hurlock Dorchester . Social Security Number if Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 XM 2 □ F (Month, Day, Year) 1945 West Virginia Months Days Hours Min. Director 234-74-1253 65 Usual Residence of Decedent show 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2 No Maryland Hurlock Dorchester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21643 USA 4133 Whiteleyville Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. è 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify White Completed 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturing Box Slitter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Esker Dee Leary Nina Ellen Watson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4133 Whiteleyville Road, Hurlock, Maryland 21643 Carol J. Leary/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Cedar Hill Cemetery 10/11/2011 Brooklyn Park, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Zeller Funeral Home, P. O. Box 207
106 Main Street, East New Market, MD 21631 21. Signature of Funeral Service Liganse Part . Enter the disease, or complications that cau led slow k, or heart failure. List only on cause on each line ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) The law requires that the death certificate be executed anding physician and use as the burial-transi-Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical δ Completed Be Certificate: To

Box 68760 P.O. Division of Vital Records, To the Hospital or Attending Physician: 'within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director

resulting in douting East.	d						
F FEMALE: 3b. Was decedent pregnant in the past 12 months?	1 Live Birth 2 Fet	23c. If yes, outcome of pregnancy 1			23d. Date of delivery Month Day Year		
1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown				IVIOTIUT Day real		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1							
Wen into	din diabe	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No				
5. Was case referred to medical		26. Place of Death (Check only one)					
examiner? 1 🗌 Yes 2 🗗 No	Hospital; 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)						
7. Manner of Death Natural 5 Pending Description		28b. Time of injury M	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju	ry occurred		
3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine		home, farm, street, factory, office ify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier 1 Certifying P	hysician: To the best of my know	ledge, death occured a	t the time, date and place, a	nd due to the cause(s) a	and manner as stated.		

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1095/133

Registrar DHMH 17 Rev 7/2009

State

Medical

29a. Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Year,

OCT 03 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jorge Abrego, MD, 598 Cynwood Drive, Suite 104, Easton, MD 21601

amend 1, per phy, 9921 11-7-11 sm Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #1 State of Maryland Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 2011 2:38 Frances E. September LEIBOWITZ Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Bethesda Montgomery Suburban Hospital 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 9. Birthplace (State or Foreign Country)
New York 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 💢 F 113-36-9856 **Director** 100 Usual Residence of Decedent show or 28a-f shov notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location rector 1 🗌 Yes 2 💢No Maryland Montgomery Bethesda ۵ 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ò er than "natural", or items 23a or the Medical Examiner must be Funeral 20814 USA 5225 Pooks Hill Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Black, White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates Specify: 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "I Elementary/Seconday (0-12) College (1-4 or 5+) Education/Community Leacher/Civic Activist Be 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev မ Dora Schulman Nathan Hindin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10709 Balantre Ln., Potomac, MD Dr. Michael Leibowitz, Son 20b. Place of Disposition (Name of 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, Judean Memorial Gardens 10/02/11 Olney, MD Torchinsky Hebrew Funeral Home Carroll St., NW, Washington, 20012 Part 1 Epler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreshock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician/ disease or condition a. Pneumonia Medical resulting in death) Due to (or as a consequence of): Examiner Abdominal Surgery Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Small Bowel Obstruction Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No To the Funeral Director, After this certificate has been signed by the atte completed filled in by the funeral director, page 2 should be detached for Month Year Day 5 Other (specify) Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Tes 2 No 3 ☐ Probably 4 ☐ Unknown Leibowitz Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director; After this certificate I 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 Yes 2 🗀 No Medical Certificate: To 1 🔀 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d Describe how injury occurred 1 🛚 Natural injury Natural
Accident
Suici 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated partitions. Nurse Practionar To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check 29b. Signature a 29c. License numbe 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009

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State

30. Name and

Muench.

Sept. 29,2011

Rockville Pike, Suite 409,

Rockville.

MD

person who completed cause of death (Item 23a) (Type, Print)

11119

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2 For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ September 28, 2011 6:00 A M John Norman Lewis Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Frederick Frederick College View Center If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days Hours April 23, 1 XM 2 F Year 1924 Ohio 87 **Director** 272-18-4052 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director Maryland Frederick Frederick 1X☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò ortant: If item 27 is marked other than "natural", or items 23a o injury or other traumatic event, the Medical Examiner must be Funeral 21701 United States 827 Dunbrooke Court death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian rmed Forces?

X Yes 2 \(\sum \) No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify.White 3 Widowed 4 Divorced Year or Dates. WWII Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien 7 is marked other th Executive Dairy Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ William V. Lewis Viola Nickels permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8522 Inspiration Ave., Walkersville, MD 21793 Suzy English Daughter Baltimore, Date 29, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Sept. 2011 cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5. ☐ Other (Specify) Resthaven Crematory Frederick, Maryland 22. Name and Address of Facility Resthaven Funeral Services, Skkot Cody P.A. 21. Signature Funeral Service Licenses Þ 9501 Catoctin Mountain Hwy. 23a. Part 1. Enter the disease, shock, or heart failure. Lis Immediate Cause (Final complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death only one cause on each line (omcev - hyurian disease or condition Medical resulting in death) Due to (or as a due Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burlan-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 5 Other (specify) Pregnant at time of death 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No 1 Yes 2 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Be Other: 4 Land Nursing Home 5 Residence 6 Other (Specify) Hospital: ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be Suicide . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 9-28-2011.

State Regist<u>rar</u> temen

31. Date filed (Month, Day, Year)

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Frederick MD 21702

Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 201 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINO MONTGOMERY LAYHILL CENTER SILVER GENESIS 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 6 Sex **Funeral** (Month, Day, March 7 Months Days Hours Min 1 □ M 2 🖾 F Ý 1933 Virginia 577-44-2059 Director 78 Usual Residence of Decedent ortant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 No Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20906 3227 Bel Pre Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black White etc. Completed by Yes 2 X No 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 ☒ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 12 Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Boas-Harris Emmett E. Roberts 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 501 Tippin Ct., Thurmont, MD 21788 19a. Informant's Name/Relationship (Type, Print) Kevin Lippold / Son Date 23, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Resthaven
Memorial Gardens 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Frederick, Maryland 21. Signature of Funer V Sacre Skkot Cody P.A. Frederick, MD 21701 Resthaven Funeral Services, any 9501 Catoctin Mountain Hwy. Frederick, ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications, or heart failure. List only one Interval Between Onset and Death e cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Examiner Due to for as a consection or of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 18 months? Month Day Year 5 Other (specify) Pregnant at time of death No 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe has 1 Yes 2 No hours after death. uneral Director: After this certificate Yes filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Hospital 1 🔲 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA ursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 27. Manner of Death 28b. Time of 28d. Describe how injury occurred injury Natural 5 Pending Accident 2 🗌 No Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide
Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 0006420 30. Name and address of person who empleted cause of death (Item 23a) (Type, Print) BELPRE ROAD, SILVER SPRING, MOOGO HUSAIN 31. Date filed (Month, 32. Registrar's Signature

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 28 2011 Physician/ 3:45 Jacob George Meiser Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Ellicott City 3005 Brookwood Road Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs Social Security Number 7. Age (In vrs. last birthday) **Funeral** Hours Director 220-09-8898 1**X** M 2 □ F 91 08/06/1920 MD 10d Inside City Limits 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
f item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County Director 1 Yes 2 X No Ellicott City Howard MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral United States 21042 3005 Brookwood Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Completed by 1 Never Married 2X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Printing Plant Manager Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Eva Edna Hurley ပ Louis Thomas Meiser 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3005 Brookwood Road Ellicott City, MD 21042 Helen Virginia Meiser - wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date permit. Page 1 a
Department of H
Important: If ite
any injury or oth cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Hanover, MD Ardent Crematory 09/29/2011 4 Donation 5 Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 Signature of Funeral Service Litensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) hronic Medical Due to (or as a consequence of) Examiner 00 na Sequentially list conditions, Examine Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury the burial-tran and that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical The law requires that the death certificate be P.O. Box 68760 use as nding ! 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No for Pregnant at time of death the the 9 | Unknown ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signed t should be det by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No. page 2 s 1 ☐ Yes 2 X No certificate 26. Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medical æ examiner? 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 🔀 No မ funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Certificate: To the Hospital or Attending F within 24 hours after death.

To the Funeral Director: After I 5 Pending work? 1 Natural 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29b. Signature and title of certifier 29c. License number

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Ye

20 10

4801 Dorsey Hall Dr., Ellicott City

0065

m. 1)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Juliana K. Selaru , 4801 Decsey Hall

Registrar's Signature

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician 0651 October 2011 Ramona Rose Mills /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner DORCHESTER CAMBRIDGE GENERAL DORCHESTER HOSPITAL 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Days Hours Maryland 217-36-0404 74 October Director Usual Residence of Decedent 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Exacting the nutitied at once. 10a. State 10b. County 10c. City, Town or Location 1 ☐Yes 2X No MD Dorchester Director Vienna 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4349 Maiden Forest Road 21869 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ∐Yes 2 No Specify. Specify: white 2 3 Nidowed 4 Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) crab picker seafood 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lillian Robinson Elwood G. Robinson 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4349 Maiden Forest Road, Vienna, MD Jason G. Mills son Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cem 10/7/11 Hurlock, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature of Funeral Service Licenses 700 Locust St., Cambridge, MD Approximate Interval Between Onser and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of which line. Immediate Cause (Final disease or condition resulting in death) **Physician** Vaus mona /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed and burial-trai Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, sate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 No 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform ueatri 1 ∐Yes 2 X No 1 ☐Yes 2 No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

William 31. Date filed (Month, Day, Year)

5

RAMONA MILLS

29c. License number

completed cause of death (Item 23a) (Type, Print) be to Combind doe,

29d. Date signed (Month, Day, Year)

and manner stated.

Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Maryland		artment of F			giene Reg. No. ?	1 !	0.00	7.0
	Physicia	n/	1. Decedent's Name (First, Middle, Last)				2. Date of Dea	ath 20	Voor	3. Tirrie of D	eath J
	Medic	al	Wilson Jacob					Septem	ber ^{Day} 29,		9:00	ам
	Examin	er	4a. Facility Name (if not institution, give s 12646 English Orc	chard Court		Silve	Location of Death r Spring			y of Death		
	Funeral Director		212-33-3324	x	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day Aug • 6	^h 1941	9. Birthpl Count	ace (State or I	Foreign
	ind show at	or	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Loc	cation				10	d. Inside City	Limits
	//anyla 8a-f s tified	Director	MD Montg	gomery	Silv	er Spring	g				1 🗆 Yes 2	. Ko No
	a or 2 be no	iO le	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Count	ry?	
	th with ms 23 must	Funeral	12646 English Or		T _{10.1}	20906		N	USA			
Maryland 21215-0036	e filed within 72 hours after death with the Maryland Ital Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates.		Vas Decedent of Hi f Yes, specify Cuba ☐ Yes 2 ^X No		ecity Yes or No- Rican, etc.)		ce - America ck, White, e Asia y:		lan
2-0	2 hour "natu edical	Completed	15. Decedent's Ed (Specify only highest grad		(Give I	lent's Usual Occupa	ation luring most of work	ing	16b. Kind of E	Business Ind	ustry	
72	ithin 7 ene. r than	Сош	Elementary/Seconday (0-12)	College (1-4 or 5+)	life. Do	NOT use retired)			Educa	tion		
d 2	filed w tal Hygi d other	Be	17. Father's Name (First, Middle, Last)	<u>J</u> T1	1040		18. Mother's Nam	ne (First, Middle,				
ylar	Mer Mer arke	<u>م</u>	Moses Daniel				Esther M	lasillan				
Mar	2 shou lith and 27 is m	90	19a. Informant's Name/Relationship (Type Mary Kutty Wilson			g Address (Street a						0906
ē,	f Healf f Healf item 2 other		20a. Method of Disposition	20b. Pla	ace of Dispo	sition (Name of		Date	20c. Location			
m0	Page nent o ant: If ury or		1 Marial 2 ☐ Cremation 3 Maria 4 ☐ Donation 5 ☐ Other (Specify,	TOTAL TOTAL OF THE PARTY	emetery, cren C Ceme	etery etery	e) Oct 20	11 ⁷ ,	Chenna	i, Ind	lia	
Baltimore,	permit, Page 1 a Department of H Important: If ite any injury or otl		21. Signature of Funeral Service License	Areral) F	Name and Addres rancis J. 00 Univer			l Home Silver	Inc. Spring	g, MD 2	0901
			23a. Part 1. Enter the disease, or compl shock, or heart failure. List only on	lications that caused the death e cause on each line.	. Do not ente	er the mode of dying	g, such as cardiac	or respiratory an	rest,		Approximate Interval Between	
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	- +0	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to or as a conseque	ence of							
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 	iysicia is cert direct	To Be	overninor?	lospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatien	Othe	or-	ome 5 Resid	dence 6 ☐ Oti	her (Specify)		
ō	ding Ph th. After th funeral		27. Manner of Death 1 ★ Natural 5 □ Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work	?	28d. Describe h	ow injury occur	red		
Sion	uttendi death stor: A y the fi	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	28e. Place of Injury - At hon	ne farm stre		Yes 2 No	28f. Location (S	Stroot and Numi	bor or Rural	Poute Numbe	_
Division of	al or A s after il Direct		4 Homicide determined	building, etc. (Specify)	, , , , , , , , , , , , , , , , , , , ,	oci, igotory, omoc		City or Tow		oer or narar	Toute Number	,
	To the Hospital or Attending Physician; within 24 hours after death. To the Funeral Director After this certific or mpleted filled in by the funeral director,	Medical	(Check 2 Medical Examin	ician: To the best of my knowle ner: On the basis of examination Practioner: To the best of my	and/or invest	igation, in my opinio	n, death occurred a	at the time, date a	nd place, and d	ue to the cau	se(s) and mani	ner stated.
-	within to the state of the stat		29b. Signature and title of certifier			29c. License	number 35596		29d. Date signe Sept		30, Year)	011
			30. Name and address of person who co	ompleted cause of death (Item 2		rint) ane, N. Beti	nesda. MI	20852				
	Stat Registra		31. Date filed (Month, Day, Year) OCT 0 3 2011	2. Registrar's Signatu								
	negistra		001 00 2011	acres po.	17	5511						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		-	State Registrar			, , , , , , , , , , , , , , , , , , , ,	Cen	tificate of E	Death	,	Reg. No. 0		329	14
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	Medic				ETH MARS					SEPTEMI			5:50	A M
	Examin	er	4a. Facility Name (if not QUEEN ANN)	-			וייידים	4b. City, Town, or CENTRE	Location of Death			nty of Death EEN AN		
	Funeral		5. Social Security Number			Age (In yrs. las		If Under 1 Year		8. Date of Birt			place (State o	or Foreign
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	he Ma or 28 o noti	Öİ	10e. Street and Number				51. FI	10f. Zip Code			10g. Citizen o	of What Cou	ntry?	
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36	filed within 72 hours after death with the Maryland tral Hygiene. So or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	d by	1 ☐ Never Married 3 🔯 Widowed 4 ☐		Armed Force 1 Yes 2 If Yes, Give Year or Dates		1	☐ Yes 2 X No	Specify:		Spec			
21215-0036	hours natur Jical E	Completed	1	5. Decedent's Ed only highest gra	ducation	,.	16a. Deced	ent's Usual Occup	ation during most of work	ina	16b. Kind of	Business Ir	ndustry	
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Maryland	should be file n and Mental I 7 is marked o raumatic eve		19a. Informant's Name	e/Relationship (Ty	rpe, Print)				and Number or Run					
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Baltimore,	permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev once.		20a. Method of Dispos 1 Durial 2 X	Cremation 3		ate CHF	ace of Dispos metery, crem SAPFAR	sition (Name of patory or other place F. CREMAT	10/0	Date	20c. Locatio	_		
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			IF FEMALE: 23b. Was decedent pre	egnant	23c. If yes, outco			T-+			23d.	Date of deli	very	
Вох	death le atte ed for	Physician/	in the past 12 mo			th 2 ∐ Fetal nt at time of d		Ectopic pregnand Other (specify)				Month	Day	Year
P.0.	res that the death cert signed by the attendir d be detached for use		9 Unknown Part II. Other significa	ant conditions co			ulting in the u	nderlying cause gi	ven in Part I.	23e. Did t	obacco use co	ontribute to	the cause of c	death?
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0 U	ding Ith. After funer	cate	27. Manner of Death 1- Natural 2 □ Accident	5 Pending Investigation	(Month,	Day, Year)	injury	28c. Injur worl M 1 =	k? Yes 2 No	28d. Describe t	now injury occ	urrea		
Division of Vital Records,	Atten er dea' ector: by the	Certificate:		6 Could not b	e 28e. Place of	Injury - At hor , etc. (Specify)	me, farm, stre	eet, factory, office		28f. Location (S		mber or Rur	al Route Num	ber,
<u>≤</u>	ital or urs afte ral Dir lled in													- 10
	Hosp 24 hou Fune eted fil	Medical	(Check 2 =	Medical Exami	ner: On the basis	of examination	and/or invest	igation, in my opini	e, date and place, a ion, death occurred a ne time, date and pla	at the time, date a	and place, and	due to the o	cause(s) and ma	anner stated.
	To the Hospital or Attending Physician: The law requires that the death cerwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attenditionable of the Funeral director, page 2 should be detached for use completed filled in by the funeral director, page 2 should be detached for use	Σ	only one) 3 L 29b. Signature and title		e Fractioner: 10	nie best of my	Miowiedge, C	29c. Licens		oo, and due to the	29d. Date sig			
			> 7 h	-Sille	Shi		MO	T)4723.	2	09	130	/201	1
Ü			30. Name and address	s of person who	completed cause	of death (Item	23a) (Type, F	Print) _ A	lary S.	Dest	iluds,	mo		
	Cto		31. Date filed (Month, I	Day, Year)	32. Red	istrar's Signat	ure	Kas	ton my	2 216	0/_			
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar F. N., T.C.H.D, PR 9/26), Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 9-21-201 Physician/ Louis Alonzo Malkus P^{M} 11:37 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** William Hill Manor Talbot Easton | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) | 10-20-1936 Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 💢 M 2 🗆 F 264-50-7584 Director 74 Washington D.C. Usual Residence of Decedent If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than """"" any injury or other than """"."" 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 🔀 Yes 2 □ No Talbot Bozman 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23311 Swan Cove Rd 21612 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2 🔀 No If Yes, Give 1 ☐ Yes 2 X No Specify: Specify: White 3 🗌 Widowed 4 🗀 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Professor Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Louis Malkus Kathryn Dille 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) wife Mary Valentine Walton Malk 23311 Swan Cove Rd Bozman MD 21612 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Chesapeake Cremation Chesapeake Cremation Center 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Stevensville, MD 9-23-2011 4 ☐ Donation 5 ☐ Other (Specify) Signa Ir of Iral Service Lie Fellows, Helienbein & Newnam Funeral Home P.A. 1200 S. Harrison St Easton MD 21601 23a. Part 1. Enter the disease, or complications tha used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on Interval Between Onset and Death Immediate Cause (Final Pnysician/ Hoda disease or condition resulting in death) Non-Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) the attending physician and hed for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Day Month Year Pregnant at time of death 2 No been signed by the should be detached 1 L Yes 2 L g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autopsy performed within 24 hours after death.

To the Funeral Director; After this certificate h 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 IDOA ၉ Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of co 29d. Date signed (Month, Day, Year) 22/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D 5 Cynwood en to

Registrar DHMH 17 Rev 7/2009

State

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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-	Examin		4a. Facility Name (if not institution, give					, Town, or					County of		_	
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	Funeral Director		5. Social Security Number 6. S 49-66-4067	ex XXM 2 □ F	ge (In yrs. I 69	ast birthday) Yrs.	Months	er 1 Year Days	If Under Hours		8. Date of Bir 3 / 01 / 1			9. Birthp Count Sout	lace (State or h Caro	Foreign lina
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	within 72 hours after death with the Maryland glene. then "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Director	10a. State 10b. County MD Prince G	eorge's		y, Town or Loc strict		hts						1"	1 X Yes	
	or 28¢	Dire	10e. Street and Number					ip Code				10a. Citi	zen of Wh	at Coun	try?	
	with th	Funeral	2910 Viceroy Ave	nue			20	747				USA				
	tems er mu	Ē	11. Marital Status	12. Was Decedent	Ever in U.	S. 13. \	Vas Dece	edent of His	spanic Orig	gin? (Spec	cify Yes or No- Rican, etc.)		14. Race -			
36	", or i	by	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X If Yes, Give	No No			2X No			noar, oto.,		Black, Specify:	White, e		
Ö	ours atural	etec	3	Year or Dates.		16a. Deced	ient's Lis	ual Occupa	ation	_	-		nd of Bus	inoss Inc	luetr/	
21215-0036	n 72 h an "na Medi	Completed	(Specify only highest gr Elementary/Seconday (0-12)	ade completed) College (1-4 or	5+)	[(Give i	kind of w	ork done di se retired)	uring most	t of workir	ng				dony	
213	within giene ner th t, the		10th	- Conogo (1 1 ch		Roofe	r					Pri	vate			
Maryland	e filed htal Hy ed oth event	To Be	17. Father's Name (First, Middle, Last)								(First, Middle,		Surname)			
Σ	d Mer d Mer mark matic	-	Benjamin Robinson			105 Mailio		(Chanat a			Singlet Route Number		Town Sta	to Zin C	ade)	
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.		Janet Spencer/Sis			852 2	1st	Stree	et N.	E. a	pt.#8 V	<i>¶as</i> hi	ngto:	n, D	C 2000	2
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ij	Page ment tant: I		4 Donation 5 Other (Speci	fy)		shingto	n Na	tiona	1 1				1and			
Ball	permit. Page 1 a Department of the limportant: If ite any injury or of once.		21. Signature of Funeral Service Licen	201001	11						rshall- Suitla					
		Н	23a. Part 1. Enter the disease, or com	plications that cause	d the deat						_	_	1110 2	770	Approximate	
	Thursinian/		shock, or heart failure. List only of Immediate Cause (Final	ne cause on each lir Metast	ie.				,,		, , , , , , , , , , , , , , , , , , , ,				Interval Betw Onset and D	/een
	Physician/ Medical		disease or condition resulting in death)	a. Due to (or as			Julia							+	<u> </u>	
	Examiner	L	Sequentially list conditions	Multi	Organ	n Failu	re									
	n #	ine	Sequentially list conditions, if any leading to immediate cause. Enter Underlying	Due to (or as	a conseq	uence olj:										
	and and -trans	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as	a conseq	uence of):								-		
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Box 68760	ficate g phys	Medi		· d												
39 ×	ending	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			Ectopio	pregnance	V			- {	23d. Date		-	
B0)	Attending Physician: The law requires that the death certificate be executed at death. **r death.** ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transity.	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant 9 ☐ Unknown	at time of		Other (Mont	th	Day Ye	ear
P.O.	nat the ed by 1 detach	/ Ph	Part II. Other significant conditions of	ontributing to death	but not res	sulting in the u	ınderlying	cause giv	en in Part	l.	23e. Did 1	tobacco u	se contrib	oute to th	e cause of de	ath?
S, F	ires the signer of the signer	Completed by	 								1 🗆	Yes 2	□ No 3	B 🗌 Prol	oably 4 🔀 L	Inknown
of Vital Records,	v requ	olete									24a. Was		24b. W	ere auto	osy findings a	vailable
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a	sician: The certificate rector, pag	Be C	25. Was case referred to medical examiner?						ace of Dea	th (Check						
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n of	ding P h. After t funera	Certificate:	27. Manner of Death 1 ☒ Natural 5 ☐ Pending	28a. Date of inj (Month, Da	ury a <i>y, Year)</i>	28b. Time of injury	М	28c. Injury work'			28d. Describe	how injury	occurred	i		
sioi	Attenc ctor: y the	rtific	2 Accident Investigatio 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In					ies z 🗆		28f. Location (Street and	d Number	or Rural	Route Numbe	er,
Division	al or / s after il Dire		4 - Hornicide determined	building, e	tc. (Specif	y)					City or To	wn, State)				
_	To the Hospital or Attending Is within 24 hours after death. To the Funeral Director, After completed filled in by the funer	Medical	29a. Certifier 1 Certifying Phy (Check 2 Medical Exam	sician: To the best o	f my know examinatio	rledge, death on and/or inves	occured a	at the time, n my opinio	date and	place, and courred at	d due to the ca	ause(s) an and place	d manner , and due t	as state	d. use(s) and mar	ner stated.
	the L	Me	only one) 3 Certifying Nur 29b. Signature and title of certifier				death occ		time, date			he cause(s		ner as st	ated.	
	S or With		1/0 Mas					\mathbb{D} 037					29/11		- 35 100)	
Ţ	0		30. Name and address of person who	completed cause of	death (Iten	n 23a) (Type, F	Print)									
R	. 4		Irina Veytsmar	110 Irv	ing S	Street,	NW	Suite	e C-2	151	Washing	gton,	DC	2001	.0	
	Sta	te	31. Date filed (Month, Day, Year)	32. Regist	rar' Signa	Box	,									

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			101	oartment of Health and N		1 1	00077
			riegistrai	ertificate of Death		1. No. 0	32911
	Physicia		1. Decedent's Name (First, Middle, Last) Jerry Kenneth Reed		2. Date of Death Month September	r 24, 2011	3. Time of Death 8:30 A M
	Medic Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			1210 Chillum Manor Road	Hyattsvill			George's
H	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda) 1 M 2 F 90 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye May 10,	9. Birth 1921 Cou	nplace (State or Foreign ntry) DC
			Usual Residence of Decedent		ind) 20 y		
	s filed within 72 hours after death with the Maryland tral Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral Director	10a. State 10b. County 10c. City, Town or Maryland Prince George's		tsville		10d. Inside City Limits 1 Yes 2 □ No
	the Ma or 28a or or in	Dire	Maryland Prince George's 10e. Street and Number	10f. Zip Code		g. Citizen of What Cou	intry?
	with t	eral	1210 Chillum Manor Road	20783		United St	ates
	death item		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 12. Yes 2 No	 Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto 	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,	
35	after al", or	Completed by	1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 3 Never Microsoft 1 Never Merried 1 Never Merried 1 Never	1 ☐ Yes 2 🖾 No Specify:		Specify: Blac	
5	hours natur Jical E	olete	15. Decedent's Education 16a. Dec	cedent's Usual Occupation re kind of work done during most of work	ing 16	6b. Kind of Business Ir	ndustry
Ž	hin 72 ne. than " ie Mec	omb	Elementary/Seconday (0-12) College (1-4 or 5+)	DO NOT use retired)	_	United S	
7 0	ed with	Be C	12th Ma 17. Father's Name (First, Middle, Last)	ster Sergeant / E-	e (First, Middle, Mai	Army iden Surname)	<u></u>
ğ	l be fill lental rked c	인	Benjamin Reed		nnette Th		
Maryland 21215-0036	age 1 and 2 should be file ont of Health and Mental I tt: If item 27 is marked o y or other traumatic eve	8		illing Address (Street and Number or Run			
≥ ô	and 2 Health em 27			Chillum Manor Roa		sville, Man	
nor	Page 1 anent of Bant: If ite	- 1	1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	rematory or other place) Octo	ber	•	
Baltimore,	permit. Page Department of Important: If any injury or once.		4 Donation 5 Other (Specify) Nation 21. Signature Fuller (Service (Censee))	22. Name and Address of Facility St		Arlington eral Home,	
ñ	Per June Per			4001 Benning Road 1			20019
			23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arrest	,	Approximate Interval Between Onset and Death
orne	Physician/ Medical	'n	Immediate Cause (Final disease or condition resulting in death)	er			Onset and Death
	Examiner		Due to (or as a consequence of):				
		iner	Sequentially list conditions, lift by Folding to In models of the Cause. Enter Underlying				
	scuted and transi	Examiner	Cause (Disease or iinjury that initiated events c. Due to (or as a consequence of):				
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	death certificate he attending physed for use as the	ian/		B Ectopic pregnancy		23d. Date of deli Month	very Day Year
20	e deat the at thed fo	Physician/Med	1 Yes 2 No 9 Unknown	5 ☐ Other (specify)		Worth	Day Tour
л Э	that th	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
as,	quires en sign				1 ☐ Yes	2 No 3 Pr	obably 4 🖾 Unknown
Vital Records,	law rec	Completed			24a. Was an autopsy	prior to c	opsy findings available completion of cause of
Y Y	: The icate !				performe		2 🗆 No
/Ita	siciar s certif	To Be	25. Was case referred to medical examiner? 1	26. Place of Death (Chec		ce 6 Other (Speci	(fy)
5	ig Phy ter this neral d	te: T	27. Manner of Death 28a. Date of injury 28b. Times	of 28c. Injury at	28d. Describe how		
o	tendir leath. tor: Af the fur	Certificate:	2 Accident Investigation	M 1 ☐ Yes 2 ☐ No	91.00		
DIVISION	l or At after o Direct I in by	Cert	4 Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stre City or Town,	et and Number or Rur State)	al Route Number,
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 X Certifying Physician: To the best of my knowledge, dear (Check 2 Medical Examiner: On the basis of examination and/or inv	th occured at the time, date and place, a	nd due to the cause	e(s) and manner as sta	ted.
	the Hohin 24 the Fu	Med	only one) 3 Certifying Nurse Practioner: To the best of my knowledg	e, death occurred at the time, date and pla	ce, and due to the ca	ause(s) and manner as	stated.
	wit cor		29b. Signature and title of certifier	29c, License number	l l	d. Date signed (Month	
	10		30. Name and address of person who completed cause of death (Item 23a) (Type	VA 0101244594	Į S	eptember 2	.9, 4011
2	12		Charles Magee, MD 8901 Rockville Pike		and 2088	9	
B.	Stat		31. Date filed (Month, Day Year) 32. Registry's Signature				
	Registra						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month September Daniel W. Spielman 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Easton Talbot Hospital Memorial If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Days Hours Min. 11-17-1927 1 🛛 M 2 🗆 F 220-18-2287 83 Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits 1

Yes 2 □ No Talbot Easton 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 817 Applewood Ct 21601 USA 12. Was Decedent Ever in U.S. Armed Forces? 1
 Yes 2 □ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced White 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Microbiologist State Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Frederick S. Spielman Sr. Elizabeth Cornwell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eva G. Spielman 817 Applewood Ct (wife) Easton MD 21601 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State Mt. Olivet Cemetery 9-30-2011 4 ☐ Donation 5 ☐ Other (Specify) Frederick, MD 22 Name and Address of Facility
Fellows, Helfenbein & Newnam Funeral Home P.A.
200 S. Harrison St Easton MD 21601 21. Signature of Funeral Service Licensee MADIN MERLE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death SMALL CELL CANCER NON LUNG disease or condition MONTHS resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter on uerrying Cause (Disease or linjury that initiated events Due to (or as a consequence of) Due to (or as a consequence of) resulting in death) Last 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ Month Day Yea Pregnant at time of death 2 No Unknown 23e. Did tobacco use contribute to the cause of death? 1 Nes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes Yes 2 No

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

DOO 66441

29d. Date signed (Month, Day, Year)

21601

SEDTEMBER

2011

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Ph_sician/ Medical Examiner Examine

Physician/

Medical

10a. State

MD

Examiner

Funeral

Director

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items 23a

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Baltimore, Maryland 21215-0036

Daniel Spielman

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Department of Health ar Important: If item 27 is any injury or other trau once.

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Director

Funeral

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Completed

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Physician/Medical

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Completed

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Certificate:

Medical

29a. Certifier

(Check

IE FEMALE 23b. Was decedent pregnant in the past 12 months? 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 \(\text{Yes} \) 2 \(\text{No} \) 1 Natural 5 Pending injury Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State

To the Hospital or Attending Physician: The law requires that the death certificate be executed

hours after death

within 24 hours a

completed

Division of Vital Records, P.O. Box 68760

RAMESH 31. Date filed (Mont State Registrar

29b. Signature and title of certifier

Klamen

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WASHINGTON ST, EASTON 2195

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Elizabeth Aileen Slacum September 30 2011 5:00a. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Dorchester General Hospital Cambridge Dorchester 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last hirthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Months Days Hours June 29 Year 1951 Marvland 219-60-1423 Director 60 Usual Residence of Decedent or items 23a or 28a-f show 10a. State traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d, Inside City Limits Director MD Dorchester Cambridge 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 1450 Cambridge Beltway 21613 USA be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 X No
If Yes, Give Black, White, etc. 1 🗵 Never Married 2 🗌 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white "natural", Specify Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked 2 Woolford Slacum Louise Elzev and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 siment of Health a tant; If item 27 is Robin L. Miller daughter 1450 Cambridge Beltway, Cambridge, MD other i 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date permit. Page 1 Department of Important: If it any injury or o cemetery, crematory or other place)
Crematory of Delmarva 1 Burial 2 X Cremation 3 Removal from State 10/1/11 Delmar. DE 4 Donation 5 Other (Specify) 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature of Funeral Service Licensee 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ respiratory arrest disease or condition Medical Due to (or as a consequence of): Examiner chronic congestive heart failure yrs Sequentially list conditions Examiner cause. Enter Underlying chronic inactive rheumatic heart disease yrs To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death 4 ☐ Pregnant a
9 ☐ Unknown the 1 ☐ Yes 2 ☐ 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ previous heart valve replacement 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? has r 24a Was an page 2 autopsy performed? Yes 2 X No After this certificate 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Yes 2 X No Other: ြု 1 Inpatient 2 X ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural iniun 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

within 24 hours after death

To the Funeral Director: A

Completed filled in by the

31. Date filed (Month, Day, Year, State Registrar

(Check

only one 29b. Signature and title of

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signatur

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

400 Eastern Shore Dr. Salisbury

29d. Date signed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland / Dep	partment of Health and M Prtificate of Death	ental Hygien Reg. ۱	2011 32980
	Physicia	n/	Decedent's Name (First, Middle, Last)	, imouto or Bour.	2. Date of Death	3. Time of Death
	Medic	al	Norma Roene Smith 4a. Facility Name (if not institution, give street and number)	I was to the state of the state	September	
	Examin	er	Malta House Assisted Living	4b. City, Town, or Location of Death Hyattsville		4c. County of Death P • G •
	Funeral Director		5. Social Security Number 511-52-6631 6. Sex 1 M 2 🗷 F 7. Age (In yrs. last birthday, 84 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year, Nov. 9, 19	9. Birthplace (State or Foreign Country) XS
	how how at	'n	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
	// // // // // // // // // // // // //	Funeral Director	MD P.G. Hyatts			1 ☐ Yes 23 No
	a or 2 be no	II Dii	10e. Street and Number	10f. Zip Code	10g. (Citizen of What Country?
	th with ms 23 must	ner	4916 LaSalle Road	20782	nif . Van au Na	USA
9800	permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Inmportant: If item 27 is marked other than "natural", or items 23a or 28a-f show amunity or other traumatic event, the Medical Examiner must be notified at the.	by	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates.	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☐ No Specify:	Rican, etc.)	14. Race - American Indian, Black, White etc. White Specify:
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ylanc	ild be file Mental H tarked of	To E	17. Father's Name (First, Middle, Last) Edgar Thomas McMillan		e (First, Middle, Maide netta Jeff	
Mar	d 2 shou alth and 27 is m ir traum			ing Address (Street and Number or Rura Newton Street, Mt.	-	
Baltimore, Maryland	age 1 and of Herent It it it it it it it it it it it it it it		T Donar 2 23 Oremation 5 11 Nemoval nomi State	matory or other place) Sep	t.30.	Location - City or Town, State
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	scuted and transit	Examiner	cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last C. Guy H (or as a consequence of):	127		
09	cate be executed physician and the burial-transit	edical E	d.			
Division of Vital Records, P.O. Box 687	the Hospital or Attending Physician: The law requires that the death certificate be executed that 24 hours after death. the Funeral Director, that this certificate has been signed by the attending physician and mpleted filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
P.O.	that the ned by detac	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death?
ds,	v requires that been signed to should be deta	ted			1 🗌 Yes	2 No 3 Probably 4 Unknown
eco	e law re has be ge 2 sh	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
<u> </u>	Physician: The law this certificate has al director, page 2 ?	Be Co	25. Was case referred to medical	26. Place of Death (Check	1 Yes 2X	No 1 Yes 2 No
	hysicii his cer Il direc	일	examiner? 1 ☐ Yes 2 ₺ No		me 5 🗆 Residence	Assisted Living 6X Other (Specify)
on of	nding P ath. r: After t e funera	icate:	27. Manner of Death 1 ♣Natural 5 Pending 2 □ Accident Investigation 28a. Date of injury (Month, Day, Year) injury	of 28c. Injury at work? M 1 □ Yes 2 □ No	28d. Describe how inj	jury occurred
ivisio	spital or Attending P hours after death. neral Director: After th d filled in by the funera	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	reet, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, ate)
_	Hospita 24 hours Funeral eted fille	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death (Check 2 Medical Examiner: On the basis of examination and/or investigations).	stigation, in my opinion, death occurred at	the time, date and pla	ace, and due to the cause(s) and manner stated.
:	७ ፮ ७ ৪	Σ	only one) 3 Certifying Nurse Practioner: To the best of my knowledge 29b. Signature and title of certifier	29c. License number	1"	Date signed (Month, Day, Year)
	8		1 Hornes	D7010Z	0	9-30-2011
			30. Name and address of pleson who completed cause of death (Item 23a) (Type, Ivan Zama MD 9200 Basil Ct., #	200, Largo, MD 207	74	
	Stat	_	31. Date filed (Month, Day, Year) 22. Registrar's Signature	V.S.		

Registrar

OCT 03 2011 Senter B.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Day 26, Month September 2011 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, 91 1 M 2XXF June 14, 1920 Yrs 10b. County 10c. City, Town or Location Baltimore 10f. Zip Code 10g. Citizen of What Country? 21218 USA

For State Registrar Decedent's Name (First, Middle, Last) Physician/ Grace C. Stancil 11:35 A.M Medical 4a. Facility Name (if not institution, give street and number) Examiner Somerford Assisted Living Social Security Number 9. Birthplace (State or Foreign **Funeral** Director 218-22-3389 North Carolina 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at anone. 10a. State 10d. Inside City Limits Director Maryland 1X Yes 2 ☐ No 10e. Street and Number Funeral 3900 the Alameda 11 Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes 2 X No If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: **Black** Specify. **¾**XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working Elementary/Secondary (0-12) life. DO NOT use retired) College (1-4 or 5+) Assemblyperson Westinghouse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Willie Covington Cora Terry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Lyles - daughter 11215 Coppermine Road, Woodsboro, Maryland 21798 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1xxBurial 2 Cremation 3 X Removal from State Sneed Grove AME 4 Donation 5 Other (Specify) 10-1-2011 Ellerbe, North Carolina Zion Cemetery 21. Sign te of Funeral Service Lines see 22. Name and Address of Facility Stauffer Funeral Home LAC 1621 Opossumtown Pike, Frederick, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ emen Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Dusity (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events and as the burial-trar Due to (or as a consequence of): resulting in death) Last the attending physician the dria by Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months Month Day Year 1 Yes 2 detached 9 Unknown signed by tall Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown been signature 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I autopsy performed within 24 hours after death.

To the Funeral Director. After this certificate I completely filled in by the funeral director, pag Yes 1 Tyes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 4 Nursing Home 5 Residence 6 2 U M Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Man r of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 hah C 31. Date filed (Month, Day, Year) SEP 3 0 Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) SEPTEMBER 27, 2011 Physician/ 8:30 a.M ROLAND CHARLES STENTON Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 501 Gateway Drive, W. Thurmont Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, June 4, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours XXM 2 □ F 88 England 106-16-9397 Director Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits should be filed within 72 hours after death with the Maryland and Mental Hygiene. Director Maryland Frederick Thurmont 1 🖾 Yes 2 🗌 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral USA 21788 501 Gateway Drive, W. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married 1xxYes If Yes, Give white Baltimore, Maryland 21215-0036 1 ☐ Yes 2XX No Specify. Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) id Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Moore Business Forms Superintendent Be 18. Mother's Name (First, Middle, Maiden Surname)
Sarah Morgan 17. Father's Name (First, Middle, Last) Walter Stenton and lisms 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once, 501 Gateway Drive, W., Thurmont, Maryland 21788 Marion Stenton - Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 A Burial 2 Cremation 3 Removal from State Thurmont, Maryland 10-1-2011 Blue Ridge Cemetery 4 Denation 5 Other (Specify) Sign ture of Funeral Service bicensee 22. Name and Address of Facility Stauffer Funeral Home 21702 1621 Opossumtown Pike, Frederick, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CANDIOVASCULAR DISCASE Onset and Death Immediate Cause (Final ATherosclereric Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any learning immediate cause. Enter Underlying Cause (Disease or iinjury Due to or as a consquence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Live Eight 2 Pregnant at time of death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ (ANCER 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown Completed Dinheres 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 🗌 Nursing Home 5 🎢 Residence 6 🗌 Other (Specify) 2 No ᅆ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 170035152 29.11

State Registrar

8x)

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MO

788

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO

2011

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32 Registrar's Signature

J.L. KRANTZ

31. Date filed (Month, Day, Year)

11-07442 Deborah Pearl S	0110		pe or Print i tate of Maryla							egible.		
Denotali Peali Si	out	1- For State	iale oi Maryli		arimeni d ertificate d		nu ivie	intal FTY		Reg. No. 2 (32983
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Medical Examir	ier	Deborah Pear1 4a. Facility Name (if not institution)		umbar\		4b. City. Town.	or Loosti -		Month October	4, 2011		1646 hrs
		11818 Philadelphia R	. •	umber)		Kingsville	or Localio	n or Death		Baltimo		
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any		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Loca	ation						10d. Inside City Limits
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eath with the Maryland items 23a or 28a-f show ust be notified at once.	Director	10e. Street and Number	1 4			10f. Zip Code			- 1	10g. Citizen of V		
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2 hours	ted	 Decedent's Education (Spe Elementary/Secondary (0-12) 			during	ent's Usual Occup most of working I	ife. DO NO	T use retire	rk done d)		ne A	· .
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		17. Father's Name (First, Middle James Pearl	, Last)					ers Name (f .zabetl		, Maiden Surnam : tum	ne)	
212 212 21d be Menta mark	To Be	19a. Informant's Name/Relation	ship (Type, Print)			ng Address (Str						
MD od 2 shoulth and ulth and aumati		Michael Souder	s / Husba			W. High			Phila Date	idelphia		
Baltimore, MD bernit. Pages I and 2 shd Department of Health and Important: If item 27 is injury or other traumati		20a. Method of Disposition 1 Burial 2 Crematio	n 3 Removal f	rom State	crematory or o		-		ber 6,	.	•	
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Box 68760, death certificate be exemple attending physician and for use as the burial -	an/Medica	IF FEMALE: 23b. Was decedent pregnant in t	h-	outcome of pres			B Ecto	pic pregnanc	-	23d. Date Month		y Day Year
Sox 687 leath certific e attending 1 for use as th	ician	past 12 months?	4 Pregi	oirm nant at time of d	anth -	etal death (Specify)	ECIO	pic pregnanc	-y 	Mona		Day Teal
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Division of Vital Records, P.O. tal or Attending Physician: The law requires that the safter death. In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact.	by	Part II. Other significant condi	dons continuating t	o death but not	resulting in the	underlying caus	a diveri iii	raiti.				bably 4 🗹 Unknown
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OD C cending sath. or: Af	tion	1 Natural 5 Pen	ding	h, Day,Yeár) L O-4-11	fd 3:3	30 pm ¹□	Yes 2	_ li	ingest	ed drug Ironment	and	was exposed
Division of Vipial or Attending Phours after death.	Certification:	3 X Suicide 6 Cou	ild not be 28e. Place	ce of Injury - At h		eet, factory, office	building,	etc. 2	8f. Location or Town,	(Street and Num State) 1181	ber or R	ural Route Number, City iladelphia Rd
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Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	(Oncor only	aminer: On the basis and manner s	of examination								
E \$ E 8	Me	29b. Signature and title of certific		1 00			nse numb	er				onth, Day, Year)
		tota U	1- To	Olle	- ^>	0.0	C.M.E.			October	o, 2011 -	
6		30. Name and address of person Patricia Aronica-Polla	•		-	900 W. Bal	timore S	Street, Ba	Itimore, N	MD 21223		
Sta		31. Date filed (Month, Day, Year)	4 9044 9	egistrar's Signat	ture	arked						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For AMEND#10a-10fperFH, 10/14/11, Brown, Nepartment of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September Physician/ 1334 PM Sherman SHAPIRO 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Montgomery **Examiner** 4b. City, Town, or Location of Death 01 ney Montgomery General Hospital Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 045-12-8789 87 Director 1 XM 2 □ F 1924 Usual Residence of Decedent Connecticut show ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Florida 10b. County Broward 10d. Inside City Limits Deerfield Beach Completed by Funeral Director Yes 2X No <u>Maryland</u> Montgomery Silver Spring 10e. Street and Number A 10f. Zip Code 33442 10g. Citizen of What Country? #301 20906 United States 3330 N. Leisure World Blvd., be filed within 72 hours after death 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc 1 Never Married 2 X Married Maryland 21215-0036 1 Yes 2 No Specify. white 3 Divorced 4 Divorced WW II 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Retail Business 0wner Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H Miriam Einbinder မ Samuel Shapiro permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic once. other traumatic 19a. Informant's Name/Relationship (Type, Print)
Joanne Shapiro, Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20 Edgecliff Road, Watertown, MA Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 🕅 Burial 2 🗆 Cremation 3 🗀 Removal from State Olney, MD 4 ☐ Donation 5 ☐ Other (Specify) Judean Memorial Gardens 10/02/11 22. Name and Address of Facility
Torchinsky Hebrew Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ gastrointestina disease or condition resulting in death) Oper Medical Due to (or as a cu Examiner cancer Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury and that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Day been signed by the a should be detached 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has upletely filled in by the funeral director, page 2 autopsy performe death? within 24 hours after death.

To the Funeral Director: After this certificate I Yes 2 No 1 🔲 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 XNo မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d, Describe how injury occurred 1XX Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier September 28 2011 0 5 ich huom 154996 30. Name and address of placen who completed cause of death (Item 23a) (Type, Print)

Bichhuong M. Dinh 18101 Prince Drive, Olney, M9 Philip

DHMH 17 Rev 06-2011

State

Registrar

Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Thonssen 6:20am Alan R. September Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Renaissance Gardens - Riderwood Silver Spring Social Security Number If Under 1 Year | If Under 24 Hrs. g. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months 1 🛛 M 2 🗆 F Hours 95 08/15/1916 washington. DC 577-01-2512 **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If tem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Silver Spring Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral u.s.A. 20904 3128 Gracefield Road, HS-521 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? 1 🗓 Yes 2 🗆 No 1940 -Black, White, etc. 1 🗓 Never Married 2 🗆 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify 3 Widowed 4 Divorced 1945 White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) C & P Telephone Co. Phone Technician Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ည William Faye Stephan Thönssen Amy Roberta Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8501 SW 22nd Court, Davie, Florida 33324 Roberta Lee Rencher - Niece 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Crematory 10/05/2011 Brentwood, Maryland 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 21. Signature of Funeral Service Licenses 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death 2 Weeks Physician/ Cerebral Hemorrhage (Non-Traumatic) disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): nding physician a use as the burial-t Physician/Medical Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy atten for u in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day 5 Other (specify) signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of To the Hospital or Attending Physician: The law is within 24 hours after death. To the Funeral Director After this certificate has E. Rempleted filled in by the funeral director, page 2 significant of the funeral director, page 2 significant of the funeral director, page 2 significant of the funeral director, page 2 significant of the funeral director, page 2 significant of the funeral director, page 2 significant of the funeral director, page 2 significant of the funeral director, page 2 significant of the funeral director, page 3 significant of the funeral director, page 3 significant of the funeral director of the funeral director of the funeral director of the funeral director of the funeral director of the funeral director of the function of the func autopsy performed? Yes 2 X N death? Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 X Yes Hospital: 2 1 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 X Natural 5 Pendina 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f Location (Street and Number or Bural Boute Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🔀 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 941 30. Name and address of person who completed cause of death (Item 23a) Type, Print)

Year

State Registrar

CRNP,

Ine Harding,

Jula

3110 Grackfield Road, Silver Spring, Maryland 20904

1-07122 /illiam David Tu	rele i s	Please Type or Print in Black Indelible Ink. Ensure			ible.	
		4 Ear State	i wentai n		, No. 2011	32986
nend item Physicia	in/	Registrar #10b. per fh. 9/28/11, Cartificate of Death 1. Decedent's Name (First, Middle,Last)		2. Date of Death	. 140.	3. Time of Death
ledical Examir	ner	William David Turkington, Jr. 4a. Facility Name (if not institution, give street and number) 14b. City, Town, or Li		Month September	22, 2011 4c. County of Death	0007 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Li Peninsula Regional Medical Center Salisbury	ocation of Death	ı	Wicomico	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year			(MM/DD/YYYY) 9. Birt	n
Director		212-56-1107 Months Days	Hours Min.	0ct. 3	1, 1950 co	untryMaryland
ku w		Usual Residence of Decedent 10a. State				10d. Inside City Limits
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J. MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland fealth and Mental Hygiene. tem 27 is marked other than "untural?, or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 10f. Zip Code 1961 Pineway 21804			Citizen of What Cour Inited Stat	
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after d	by Fi	3 Widowed 4 Divorced If Yes, Give Year or Dates:			Specify:	hite
hours "natur		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation during most of working life. I			16b. Kind of Business/li	
1215-0036 Id be filed within 72 fental Hygiene narked other than '	Completed	12 Pewter Design	ner		Retail S	ales
e, MD 21215-0036 I and 2 should be filed within 7 Health and Mental Hygiene. Them 27 is marked other than r traumatic event, the Medica		17. Father's Name (First, Middle, Last) William Turkington, Sr.		(First, Middle, Ma	urkington	
212 uld be Menta marke	To Be	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street a				Zip Code) 21826
MD d 2 sho Ith and Ith		William Turkington, SrFather Po, Box 15, 10				d, Md.
Baltimore, MD 21 permit. Pages I and 2 should Department of Health and Me Important: If item 27 is ma injury or other traumatic or		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of ceme crematory or other place)			20c. Location - City or	
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite Important:	I	4 Donation 5 Other Specify: St. Peters U, M. 21. Signature of Funeral Service Licensee 22. Name and Address of	of Eacility			Md.
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Physician //Medical		23a. Firt I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, st failure. List only one cause on each line.	uch as cardiac o	r respiratory arres	st, shock, or heart	Approximate Interval Between Onset and
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Box 68760, e death certificate be exc the attending physician of for use as the burial	/Med	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the	7		23d. Date of delivery	
ox 687 eath certific attending i	cian	past 12 months? 1 Live birth 2 Fetal death 3 past 12 months? 4 Pregnant at time of death 5 Other (Specify)	Ectopic pregna	ancy	Month D	ay Year
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F Vit	2	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA O 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury			esidence 6 Other	:
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Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been sited in by the finneral director, page 2 should be a by the finneral director, page 2 should be a by the finneral director.	ifica	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office built	ilding, etc.	28f. Location (St or Town, Sta	reet and Number or Ru	ral Route Number, City
Dispital hours a meral I	Certific	4 Homicide determined (Specify) Nursing Home		105 Times Squ	are, Salisbury, MD	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burit	dical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, or				
To Time To	Medi	and manner stated. 29b. Signature and title of certifier 29c. License	number		29d. Date signed (Mor	th, Day, Year)
JOA		Pati Grani - Hollies O.C.M	1.E.		September 22, 2	011
Mo		 Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 900 W. Baltimo 	ore Street, B	Baltimore, MD	21223	
Sta		21 Date filed (Month Day Voor) 32 Registrat's Signature			····	
Regist		SEP 2 8 2011 Sever A. Jak				
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			For State	State of Marylan	d / Depai	rtment of He	ealth and	Mental Hy	giene n	11 32987
		_	Registrar 1. Decedent's Name (First, Middle, Last)		Cert	ificate of De	eath		Reg. No.	
I	Physicia Medic	cal	Robert Mo	mis -		MS		2. Date of Dea	ben 28	Year 6:26AM
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	Funeral Director		210-30-1100	2 F 7. Age (In yrs. la			If Under 24 Hrs Hours Min.	SEPT. 2,	1950	9. Birthplace (State or Foreign MARYLAND
	and show 1 at	ē	Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Loca	tion				10d. Inside City Limits
	Maryl 28a-f otifie	Director	MD QUEEN ANN	E'S HEI	NDERSON					1 Yes 2 X No
	ith with the Maryland ms 23a or 28a-f show must be notified at	Funeral D	10e. Street and Number 3520 GOLDSBORO RD			10f. Zip Code 21640			10g. Citizen of USA	
9800	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygene. If firem 27 is marked other than "natural", or items 23a or 28a-f sho if item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at	출	1 Never Married 2 X Married	Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates.	If \	as Decedent of Hisp res, specify Cuban, Yes 2 X No	Mexican, Puert			ce - American Indian, ick, White, etc. v: WHITE
Maryland 21215-0036	within 72 hou giene. ner than "nat t, the Medica	Completed		ompleted) College (1-4 or 5+)	(Give kir	nt's Usual Occupation of work done dur NOT use retired)		king	The Section	Business Industry
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Ball	permit. Page Department Important: I any injury o		21. Signatur Funeral Service Licer e	frus	22.1 FEL 408	Name and Address LOWS, HELF S. LIBER	of Facility FENBEIN TY ST	& NEWNAL	M FUNERA	AL HOME, P.A. MD 21617
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)			30. Name and address of person who comple Michael Allis Six	22 Sociation (Item)	vth 6	reene	Stre	et Ba	Himor	re, MD21201
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Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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		For State Registrar		,		tificate				-	Reg. No 2		3298	8
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Examin	er	4a. Facility Name (if not institution 6648 Peachblos	som Point			4b. City, To East	on				Tal	nty of Death bot		
Funeral Director		5. Social Security Number 230-54-5174 Usual Residence of Decedent	6. Sex 1 □ M 2 🔀 F	Age (In yrs. I	last birthday) Yrs.	If Under 1 Months	Year Days	If Under 2 Hours	Min.	8. Date of Bir 1 0 2 9 - 1		9. Birth Cou	pplace (State or Foreigntry) DE	gn
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Ma	12. Was Deceder Armed Forces 1 Yes 2	?	lf.	/as Deceden Yes, specify	Cuban,	, Mexican,	in? (Sper Puerto F	cify Yes or No- Rican, etc.)	Е	lace - Ameri lack, White	etc.	
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⊕ ⊑ .©		resulting in death) Last	Due to (or a	s a consequ	uence of):									
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TLS 15		30. Name and address of person	who completed cause of	death (Item	23a) (Type, Pr	int) O	7 /) str	hu	nan's	Lan	e, C	Eastan 1	ne
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Cambridge Bay Nursing Dorchester HOME 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 7-882 1 M 2 F Months (Month, Day, Year) **Director** items 23a or 28a-f shov th and Mental Hyglene. 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🗹 No aylors 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married à permit, Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event; the Medical Examin gones. ☐ Yes Yes, Give Baltimore, Maryland 21215-0036 1 🗆 Yes 2 🗹 No Completed 3 Divorced 4 Divorced lack Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Processing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20o. Location - City or Town, State Date 1 D Burial 2 Cremation 3 CRemoval from State Cemetery 4 Donation 5 Other (Specify) 10 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Home, P. Ar Henry Funeral 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ DEMENTIA. STAGE Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): as the burial-transit Due to (or as a consequence of): signed by the attending physician I be detached for use as the buria Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 month 1 Yes 2 No 3 Ectopic pregnancy Day Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 \$\infty\$ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ♣ No 24a. Was an certificate has autopsy performed? Yes 2 P No 2 🎒 No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifies completed filled in by the funeral director, Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: _2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Deat 28b. Time of 28c. Injury at 28d. Describe how injury occurred A Natural 5 Pending iniury work?
1 Yes Accident Investigation 2 🗌 No 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🖟 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie MD D 69234 03 and address of person who completed cause of death (Item 23a) (Type, Print) STREET ERRABOLU 503 ByRn CAMBRIDGE MD 21613. 31. Date filed (Month, Day, Year) State

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Registrar

State of Maryland / Department of Health and Mental Hygiene

	1	For State Registrar		Cer	tificate of l	Jeain	Reg	. No.	32990
Physician	n	1. Decedent's Name (First, Middle, Last) RICHMOND	,	WEAVER			Month	Day Year 2011	10:29A M
/Medica Examine		4a. Facility Name (If not institution, give s			4b. City, Town, or	Location of Death		4c. County of Death	
2	4	7904 Holiday Avenu		4 6 inth alo : 1		shington If Under 24 Hrs.	8. Date of Birth	Prince Ge	orge's place (State or Foreign
uneral irector	,		7. Age (In yrs. I	Vrs	Months Days	Hours Min.	(Month, Day, Y	'ear) Cou	h Carolina
rector	-	Usual Residence of Decedent	95)			03/09/19	10 NOIL	ii carorina
how	.	10a. State 10b. County		, Town or Lo					10d. Inside City Limits
sa-f s tiffied	Director	MD Prince Ge	orge's For	t Wash	nington				1 X Yes 2 No
or 28		10e. Street and Number			10f. Zip Code			g. Citizen of What Cou	intry?
s 23a nust	<u>s</u> a	7904 Holiday Avenu		5 12 1	20744	ionanio Orlain? (Sn	US poits Ves or No-	A 14. Race - Amer	ican Indian.
ltem iner r	Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married	 Was Decedent Ever in U. Armed Forces? Yes 2 No 			ispanic Origin? (Spe an, Mexican, Puerto	Rican, etc.)	Black, White	, etc.
al", or	2	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates: WW-I	I 1	☐ Yes 2☐XNo	Specify:		Specify: B1	.ack
ical E	Completed	15. Decedent's Educ (Specify only highest grade	ation	16a. Deced	lent's Usual Occup	ation		6b. Kind of Business/I	ndustry
an "r Med	edu	Elementary/Secondary (0-12)	College (1-4or 5+)	Brick		during most of work i)	P	rivate	
t, the	5			DITCK	Tiason	40. Mathada Name	e (First, Middle, Ma	oidon Curnama)	
ever ever	ň	17. Father's Name (First, Middle, Last)				Sudie We		alderi Surname)	
narke	٥.	Unknown 19a. Informant's Name/Relationship (Typ.	oo Print)	10h Mailin	a Address (Street			City or Town, State, Z	in Code)
7 is matraum		LaVerne Weaver /	•					ngton, MD	
Important: If item 27 is marked other than "natural", or liems 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	-	20a. Method of Disposition	20b. P		sition (Name of natory or other place			0c. Location - City or	
ant: If ite ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Ro 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		Cemetery	1	01/2011 B	ethel, NC	
h lu	Ì	21. Signature of Funeral Service License						rch Funera	1 Home
any Ir	1	1 may 1	oderich	43	308 Suit1	and Road	Suitland	, MD 20746	
		23a. Part1. Enter the disease, or complications, or heart failure. List only on	cations that caused the death	n. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory arres	st,	Approximate Interval Between
sician	Ì	Immediate Cause (Final disease or condition	COMPLICATIO						Onset and Death
edical		resulting in death)	Due to (or as a consequ	uence of):					
miner	_	Sequentially list conditions, b		inner of					
ısit	Examine	Sequentially list conditions, and year of introducts cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consec	derice ori:					
al-trar	xan	that initiated events c resulting in death) Last	Due to (or as a conseq	uence of):					
phy:	edical								
attending for use	2	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome pf pregna		Ectopic pregnanc	,		23d. Date of del	
e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown		Other (specify)	·		Month	Day Year
signed by the a	Physician/M	9 □ Unknown							
		Part II. Other significant conditions con				en in Part I.		acco use contribute to	
should b	ed	CHRONIC OBSTRUCTIV	E PULMONARY I	DISEASI	<u> </u>		1 Yes	S 2[]NO 3[]PI	obably 4 Munknow
9 4 17	<u>e</u>	PROSTATE CANCER					24a. Was an		topsy findings availab
as t							autopsy		completion of cause of
page 2 s	E						perform	death? No 1 ☐ Yes	
sertificate has t	Be Completed by	25. Was case referred to medical examiner?	lasnital-		0"		perform 1 Yes 2	ed? death? ☐ No 1 ☐ Yes	
this certificate has b al director, page 2 sl	To Be	examiner? 1 ☐ Yes 2 No		ER/Outpatier		er: 4 ☐ Nursing H	perform 1 Yes 2 th (Check onlone ome 5 TReside	death? ☐ No 1 ☐ Yes conce 6 ☐ Other (Spe	2 X No
After this certificate has t funeral director, page 2 s	To Be	examiner? 1 □ Yes 2 No 27. Magner of Death 1 □ Natural 5 □ Pending	lospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury	f 28c. Inju	er: 4□ Nursing Hory at k?	perform 1☐ Yes 2 th (Check onlone	death? ☐ No 1 ☐ Yes conce 6 ☐ Other (Spe	2 📉 No
ctor: After this certificate has t	To Be	examiner? 1 Yes 2 No 27. Magner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Inju Wor M 1	er: 4 ☐ Nursing H	perform 1 Yes 2 th (Check onl one ome 5 Resider 28d. Describe hor	death? ☐ No 1 ☐ Yes conce 6 ☐ Other (Spe	2 □XNo cify)
Director: After this certificate has the in by the funeral director, page 2 s	To Be	examiner? 1	28a. Date of Injury	28b. Time o Injury	f 28c. Inju Wor M 1	er: 4□ Nursing Hory at k?	perform 1 Yes 2 th (Check onl one ome 5 Resider 28d. Describe hor	death? 1 Yes nce 6 Other (Spewinjury occurred	2 □ X No cify)
Funeral Director: After this certificately filled in by the funeral director	Certification: To Be	examiner? 1 Yes 2 No 27. Magner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined 29a. Certifier 1 Certifying Phys	28a. Date of Injury (Month, Day Year) 28e. Place of injury - At he	28b. Time o Injury	f 28c. Inju Wo M 1 Ceet, factory, office	ier: 4 Nursing Hory at k? Yes 2 No	perform 1 Yes 2 th (Check onl one 5 Resider 28d. Describe how 28f. Location (Str. City or Town, and due to the ca	death? 1 □ Yes nce 6 □ Other (Spewinjury occurred reet and Number or Rights, State)	2 (XNo cify) ural Route Number, s stated.
Funeral Director: After this certificately filled in by the funeral director	To Be	examiner? 1 Yes 2 No 27. Magner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 29a. Certifier (Check only) 1 Certifying Phys	28a. Date of Injury (Month, Day Year) 28e. Place of injury - At he building, etc. (Specifician: To the best of my knoner: On the basis of examina	28b. Time o Injury	f 28c. Inju Wo M 1 Ceet, factory, office h occurred at the ti vestigation, in my 29c. Licens	ier: 4 Nursing Hory at k? Yes 2 No me, date and place opinion, death occuse number	perform 1 Yes 2 th (Check onl. one ome 5 Resider 28d. Describe hor 28f. Location (Str. City or Town, and due to the carred at the time, da	death? 1 Yes noe 6 Other (Spe w injury occurred weet and Number or Ri State) use(s) and manner a ate and place, and du dd. Date signed (Moni	cify) ural Route Number, s stated. e to the cause(s) th, Day, Year)
To the Funeral Director: After this certificate has b completely filled in by the funeral director, page 2 si	edical Certification: To Be	examiner? 1 Yes 2 No 27. Magner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one)	28a. Date of Injury (Month, Day Year) 28e. Place of injury - At he building, etc. (Specifician: To the best of my knoner: On the basis of examina	28b. Time o Injury	f 28c. Inju Wo M 1 Ceet, factory, office	ier: 4 Nursing Hory at k? Yes 2 No me, date and place opinion, death occuse number	perform 1 Yes 2 th (Check onl. one ome 5 Resider 28d. Describe hor 28f. Location (Str. City or Town, and due to the carred at the time, da	death? 1 □ Yes nce 6 □ Other (Spe w injury occurred reet and Number or Ri State) suse(s) and manner a ate and place, and du	cify) ural Route Number, s stated. e to the cause(s) th, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 24 Physician/ 52 M 201 Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner HOPKING 7. Age (In vrs. last birthday If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year Hours Mir Virginia **Director** 214-87-7794 an. 2010 Usual Residence of Decedent Januarv er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 🗌 Yes 2 🎇 No Maryland Frederick Jefferson 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5208 Crest Court 21755 United States · death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14 Race - American Indian Armed Forces? Black, White, etc. 1 🗷 Never Married 2 🗌 Married Š Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other transmitted. Elementary/Seconday (0-12) College (1-4 or 5+) 0 None Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Mark Richard Widmaier Stephanie Lucile Mc Sherry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5208 Crest Court Mark R. Widmaier / Father Jefferson. Marvland 21755 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State September 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Mem Gardens 30, 2011 Frederick, Maryland 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, Maryland 21702 23a. Part 1. Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Acidosus disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death 5 Other (specify) the P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? Was an autopsy performed? has certificate 1 Yes 2 No Yes 2 ☐ No To the Hospital or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 🖸 No ည 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DCA 24 hours after death.

Funeral Director: After this eleted filled in by the funeral dir 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 😿 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho

To the Fune Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES - 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 N. Wolfe St. Baltimore MD 21287 NOJ CORINA 31. Date filed (Morth

DHMH 17 Rev 7/2009

State

Registrar

ank

32 Registrar's Signature

11-07633 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Kala Marie Austin State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day October 12, 2011 0850 hrs **Medical Examiner** Marie Austin 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Baltimore Washington Medical Center Anne Arundel Glen Burnie If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Sociel Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Months Days Hours Director Country) 2 X F 1 M 17 03/11/1994 215-41-4638 Maryland Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a State 10b County 1 Yes 2 No Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene. Important: If item 27 is marked other than "antural", or items 23s or 28s-f show injory or other tranmatic event, the Medical Examiner must be gotified at socc. Maryland Anne Arundel Pasadena Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3612 Robin Air Court 21122 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married 2 X No Ves 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: Specify: White Š 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 11 N/A Student Student 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna M. Austin (Mother) 3612 Robin Air Court Pasadena Maryland 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 Removal from State Glen Haven Mem. Pk. 10/17/2011 Glen Burnie, Maryland 4 Donation 5 Other Specify. 21. Signature of Furieral Service Licenses 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland Me 23a. Part LEnter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval **Physician** Between Onset and fallure. List only one cause on each line /Medical Death a. Multiple Injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and or use as the burial - transit sician/Medical UNPENDED AMENDED Division of Vital Records, P.O. Box 68760 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b Was decedent pregnant in the 3 Ectopic pregnancy 1 Live birth 2 Fetal death Month Day Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 V Unknown is been signed by the attraction should be detached for 9 Unknown Phys 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of certificate has performed? , page 2 death? Yes 2 No 2 No 1 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other Nursing Home 5 Residence 6 Other. this (2 PER/Outpatient 3 DOA 1 V Yes 2 After t 28a. Date of Injury (Month, Day, Year) Oct 12, 2011 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Driver of motor vehicle which struck fixed object Natura 5 Pending 1 Yes 2 ✔ No within 24 hours after death.

To the Funeral Director: the 2 🗸 Accident Investigation in by 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) 4424 Mountain Road, Pasadena, MD (Specify) Local Street Homicide 29a. Certifier (Check only one) 2 completely Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. October 13, 2011 30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registra

DHMH 17 Rev 1/2001 OCME 2006

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 08 Physician/ October 201 Myah Rene Arnold Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** S. 8. Date of Birth itos Pita Johns HOPKINS Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** (Month, Day Year) Director None 1 🗆 M 2 🗶 F Oct. 11, 2011 Maryland 1 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location Director 1 Yes 2 No Maryland Harford Joppa 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21085 USA 630 Cider Press Loop hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc 1 X Never Married 2 Married by Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) ŃΑ None Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Andrew Milton Arnold Michelle Rene Weaver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Andrew Arnold / Father 630 Cider Press Loop, Joppa, Maryland 21085 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mountain Christian Chr. 10-16-2011 Joppa, Maryland 21. Signatura of Funeral Service Lic 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician espiration disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last ma L burial-tran attending physician and Due to (or as a conseque of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No jo Month Day Year Pregnant at time of death the a signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an page 2 performed? Yes 2 No certificate funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No 24 hours after death. Funeral Director: A Investigation Accident filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2. To the F only one) 29b. Signature at 29d. Date signed (Month, Day, Year) tober 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mD M. Wolfe tarawa 600 mif 31. Date filed (Month, Day, 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. N2 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician/ Month Beazley Kimberleia O 2011 01:28 Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death Examiner 4c. County of Death N/A Mary land Medical center Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. (Month, Day, 5. Social Security Number g. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🗶 F 215-96-8557 Yrs Director 13 1966 Maryland Usual Residence of Decedent 28a-f shov 10b, County aţ 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 1 🗆 Yes 2 🔀 No Maryland Worcester Berlin ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 836 Ocean Parkway 21811 United States Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black, White, etc 1 Yes 2 No If Yes, Give Year or Dates. 0 ş 1 Never Married 2 Married Saltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: WHITE Specify: "natural", 3 Widowed 4 X Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7:
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than any injury or other traumation. Elementary/Seconday (0-12) College (1-4 or 5+) year Disabled Disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Karl F. Beazley Donna Kradz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Kradz - MOTHER 836 Ocean Parkway, Berlin, Maryland 21811 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 Burial 2 X Cremation 3 Removal from State Donation 5 Other (Specify) Metro Crematory INC 10-17-2011 Baltimore, Maryland 22. Name and Address of Facility Cremation Society Of Maryland INC neral Service Licensee 21. Signature of 299 Frederick Road, Baltimore, MD 21228 Part 1. Enter the disease, or complications that caused the c shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph sician Varicea disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or iinjury physician and the burial-transit The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 attending p IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 2 No detached 9 Unknown Unknown Division of Vital Records, P.O. signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy page perform death? 1 ☐ Yes 2 🔼 No 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Npatient 2 ER/Outpatient 3 DOA After this 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No 1 X Natural 5 Pending injury after death. Director: Af Accident Investigation the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) 24 hours a Funeral I Medical 1 **Executifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD 10 1659670214 2011

Registrar
DHMH 17 Rev 7/2009

State

medical center

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Maryland

8

of

31. Date filed (Month

JUSTIN BRITTON MD

22 S. Greene

Balt, more

HD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October Physician/ Ralph 10:30 A · M 2011 Medical 14 4c. County of Death **Examiner** Dath more If Under 24 Hrs. 8. Date of Birth (Month, Day, Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min. Months Hours Director 1 M 2 □ F Yrs. ms 23a or 28a-f show must be notified at 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director 1 Nes 2 No 10f. Zip Code 10g. Citizen of What Country? 1214 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian or other traumatic event, the Medical Examiner Armed Forces? Black White etc. 1 Never Married 2 Married ō Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates "natural", 3 Widowed 4 Divorced a. veveaent's Usual Occupation (Give kind of work done during most of working the DO NOT use retiret) 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) 2 should be filed within 72 th and Mental Hygiene. 77 is marked other than "1 glary (0-12) College (1-4 or 5+) 101 Ken Be ပ City or Town, State, Zip Code, 181 oister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crem ☐ Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lic 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heat failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Cancer Physician/ LUNG Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of). as the burial-transit that the death certificate be executed Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 IF FEMALE: nse yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Year Month Pregnant at time of death 5 Other (specify) 1 Yes 2 No detached 9 Unknown P.O. by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires t within 24 hours after death.

To the Funeral Director: After this certificate has been sign Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: မ 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural work?
1 Yes 2 No 5 Pending Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated ns Rajapalnim.D 29b. Signature and title of certifier . 10/14/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Balhmore MD 21209 Kajapakse Min. 2835 Smith 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 8 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Maryla		artment of I		Mental Hy	20	113	2996
			Registrar 1. Decedent's Name (First, Middle, La	st)	Cer	lilicale of L		2. Date of De	Reg. No.		Time of Death
	Physicia		madae	_				Month	Day	Year	8.4
	Medic Examin		4a. Facility Name (if not institution, give	street and number)		4b. City, Town, o	r Location of Dea	LOCTODE		y of Death	_0315
			Casey House			Rockvill	e		Monto	merv	
1	Funeral		Social Security Number 6. 5	3-1,	rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		th		e (State or Foreign
	Director		413_22_0109 Usual Residence of Decedent	□ M 2 🗙 F	87 Yrs.			Nov 12	1923	Tennes	ssee
	and show	or	10a. State 10b. County	10c.	City, Town or Lo	cation				10d.	Inside City Limits
	Maryl 28a-f otifie	irec	MD Montgome	ery Si	lver Spr	ring					1 ☐ Yes 2 X No
	h the	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Country?	
	th wit ms 2; must	ner	13213 Holdridge B		110 140 1	20906	0.11.07		USA		
(0	or ite	by Fu	11. Marital Status1 ☐ Never Married2 ☐ Married	12. Was Decedent Ever in Armed Forces?	0.5.	Was Decedent of H f Yes, specify Cuba	an, Mexican, Puer	to Rican, etc.)	14. Ra Bla	ce - American I ack, White, etc.	ndian,
21215-0036	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho er the Medical Examiner must be notified at , the Medical Examiner must be notified at	ed k	3 Widowed 4 Divorced	1 ☐ Yes 2 😿 No If Yes, Give Year or Dates.		∣ ☐ Yes 2X No	Specify:		Specify	white	
5-0	2 hou "natu edica	Completed	15. Decedent's E (Specify only highest gi			dent's Usual Occup		orking	16b. Kind of E	Business/Indust	ry
12	thin 7 ene. than	Som	Elementary/Secondary (0-12)	College (1-4 or 5+)		O NOT use retired)					
	filed wi al Hygie d other	Be	17. Father's Name (First, Middle, Last)	1	Homema	ker	18. Mother's Na	ame (First, Middle,	Own Ho	1110	
lan	d be fi dental rrked tic ev	오	Clifford B. Arnol	ıd				ne Ruth			
Maryland	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (ng Address (Street				State, Zip Code	э)
	1 and 2 of Health item 27 other tr		Sandra Leigh Red			Mahaska	Dr. Derw				
Baltimore,	Page 1 annent of Hannert of Hanne		20a. Method of Disposition 1 ☐ Burial 2 【▼ Cremation 3 ☐	Removal from State		natory or other plac	· i	Date		- City or Town,	State
ij	permit. Page Department of Important: If any injury or once,		4 Donation 5 Other (Special Signature of Funeral Service Licen	11:	22	rney Cre	ss of Facility	O 100		100	
ñ	permi Depar Impor any ir	1	12 every f	He litter	ĮGo	oing HOme	Cremati	on Servi	ce P.C	Box 7	784 MD 21029 J
	-		23a. Part 1. Enter the disease, or comshock, or heart failure. List only		leath. Do not ente	er the mode of dyin	ıg, such as cardia	c or respiratory a	rest,	Ap	proximate erval Between
	Ph, sician/		Immediate Cause (Final disease or condition	a Cancer of						On	nset and Death
made	Medical Examiner		resulting in death)	Due to (or as a cons							
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	uted d ansit	Examiner	Cause (Disease or injury that initiated events								
	be executed sician and burial-transit		resulting in death) Last	Due to (or as a cons	equence of):						
90	0 50	dical		d							
Box 687	The law requires that the death certificate are has been signed by the attending phy. page 2 should be detached for use as the	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of preg	gnancy				224 D	ate of delivery	
ŏ	eath c atten	iciar	in the past 12 months?	1 Live Birth 2 F	etal death 3	Ectopic pregnand Other (specify) _	су			onth Day	y Year
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P.O.	s that gned be de	by	Part II. Other significant conditions	ontributing to death but not	resulting in the u	nderlying cause gi	ven in Part I.		obacco use con		
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Vita	/sicia s certi direct	To Be	examiner? 1 \(\sum \) Yes 2 \(\foxtime \) No	Hospital:	☐ EB/Outpatier	Oth	er:	Home 5 Resi	danca 617 Oth	per (Specify). L	
ot	ng Phy ter thi neral		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of injury (Month, Day, Year)	28b. Time of	28c. Injur	y at		now injury occur		ospice
lon	tendir leath. or: Af the fu	ifica	2 Accident Investigatio 3 Suicide 6 Could not be	n		M 1 🗆	Yes 2 No				
Division of Vital Records,	or At after o Direct in by	Certificate:	4 Homicide determined			eet, factory, office		28f. Location (City or Tou	Street and Numb vn, State)	per or Rural Rou	ute Number,
	spital		29a. Certifier 1 Certifying Phy	sician: To the best of my kno	owledge, death of	occurred at the time	e, date and place	and due to the c	ause(s) and man	ner as stated.	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director,	Medical		iner: On the basis of examina se Practitioner: To the best of							
	To the Coal		29b. Signature and title of certifier			29c. Licenso	e number		29d. Date signe	ed (Month, Day,	Year)
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١	01		30. Name and address of person who				na				
	Stat	e	Nicole Christenso	32 Registrar's Sig	nature	-	ka. Kock	ville, M	D 20855		
3-	Registra		OCT 1 8 20	11 Derma	B. pa	New .					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 26 per verb 9920 10-18-11 vt State of Maryland / Department of Health and Mental Hygiene State Registrar 32997 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Alfred P. Brainard 2011 16, Medical 0920 October 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Casey House Rockville Montgomery Social Security Numbe 8. Date of Birth (Month, Day, If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday **Funeral** 9. Birthplace (State or Foreign 1**X** M 2 □ F Hours New York **Director** 092-26-2859 79 30. 1932 uq Usual Residence of Decedent 28a-f shov 10a. State 10b. County Examiner must be notified at 10c, City, Town or Location 10d. Inside City Limits Director MD Montgomery Bethesda 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 8112 Thoreau Drive USA 20817 death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 □ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian ò 1 Never Married 2 Married Black, White, etc. ģ Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify: "natural", Completed 3 Widowed 4 Divorced Specify: White Year or Dates. 1954–62 the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed wir Department of Health and Mental Hygie Important: If item 27 is marked other Diplomat Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alfred P. Brainard Jennie E. Heil 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joanne Elegant Brainard/wife 8112 Thoreau Drive Bethesda, MD 20817 Baltimore, 20a Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of H Date 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State 4 Donation 5 Other (Specify) injury or cemetery, crematory or other place) Final Journey Crematory 10/18/11 Woodbine, MD 21. Signatus of Funeral Service Licenses 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Phynician disease or condition resulting in death) a Paralysis Agitan Medical Examiner Malignant Neoplasm of Mediastinum Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence or, or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury use as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician d be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pneumonia Completed 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available 24a. Was an has page 2 autopsy prior to completion of cause of death? certificate 1 ☐ Yes 2 🗓 No 1 Yes 2 No ours after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 💢 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6X Other (Specify) hospice 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital of within 24 hours a To the Funeral C completed filled in the completed filled in the completed filled in the completed filled in the completed filled in the completed filled in the completed filled in the completed filled in the completed filled in the completed filled in the completed filled in the completed filled in the completed filled in the completed filled in the complete completed filled in the completed filled filled in the completed filled filled in the completed filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🕱 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c, License number 29d, Date signed (Month, Day, Year) R120698 October 16, 2011 Mister (30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nicole Christenson, CRNP 6001 Muncaster Mill Rd. Rockville, MD 20855 31. Date filed (Month egistrar's Signatur State 18 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 10^{bay} 2011 11:19 A M Anne Catherine Bruce Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 X F Days Months December 11, Hours Country) Virginia **Director** 23-34-7210 80 1930 Usual Residence of Decedent 10a. State 10b. County with the Maryland aţ 10c. City, Town or Location Director 10d. Inside City Limits r 28a-f s notified 1 X Yes 2 No Maryland Montgomery Rockville ō 10e. Street and Numbe 10f. Zip Code must be 10g. Citizen of What Country? Funera 1494 Kimblewick Road 20854 United States 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or ite 14. Race - American Indian, Black White etc. þ 1 X Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give 1 Yes 2 No Specify. Completed 3 Divorced 4 Divorced Specify: White Year or Dates of Health and Mental Hygiene.
Item 27 is marked other than "natul other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Charles A. Bruce Della Plunkett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Charles S. Schrader, Sr./ Nephew 1142 Avondale Drive, Lynchburg, Virginia 24502 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date injury or 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place. October 15, 2011 4 ☐ Donation 5 ☐ Other (Specify) Presbyterian Cemetery Lynchburg, Virginia 21. Signature of Fundry Service ase Robert A. Pumphrey Funeral Home, Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave, Bethesda, Maryland 20814 M01619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final set and Death Physician/ disease or condition resulting in death) minutes Medical Due to (or as a consequence of) Examiner hour pirator Sequentially list conditions. Examine if a y, leading to ministrate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) attending physician and for use as the burial-transi resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day been signed by the should be detached Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown has been signed by the second 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy After this certificate he funeral director, page perform death? Yes 2 Be 25. Was case referred to medica examiner? 26. Place of Death (Check only one) ျ 1 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No Director: / Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cer, MD D0068488 erson who completed cause of death (Item 23a) (Type, Print) 30. Name and address of 9901 medical Rockville, MD 20150 Jesse Cor Dr MD Day, Year) State Registrar

11-07524 Joseph Berry Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

,		I- For State Certificate of Death Registrar	~	eg. No. 201	32999
Physiciar Medical Examin		1. Decedent's Name (First, Middle,Last) JOSEPH NATHANIEL BERRY	2. Date of Dea Month October 7		3. Time of Death 1605 hrs
The state of the s		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 8201 Meadowfield Way Laurel		4c. County of Dear	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs.		rth(MM/DD/YYYY) 9. Bi	rthplace (State or
Director		427-48-4269 1 X M 2 F 93 Yrs. Months Days Hours Min.		, 1918 Fore	gn ountry) MS
/ any	ŀ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
Maryland 28a-f show	후	MD Prince George's Laurel 10e. Street and Number 110f Zin Code			1 Yes 2xx No
the Mar a or 28a	Director	10e. Street and Number 10f. Zip Code 20708	1	Og. Citizen of What Cou	untry?
72 hours after death with the Maryland n "astural", or items 23a or 28a-f shoal Examiner must be notified at once.	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp. 1 Never Married 2 XX Married Armed Forces? 15. Was Decedent of Hispanic Origin? (Sp. 15. Was Decedent of Hispanic Origin? (Sp. 16. Was Decedent of Hispanic Origin? (Sp. 16. Was Decedent of Hispanic Origin?)			rican Indian, Black,
	by Fu	1 X Yes 2 No 3 Widowed 4 Divorced If Yes Give Year WWII 1 Yes 2 No specify:		Specify: B]	Lack
5-0036 led within 72 hours afte Hygiene. other than "natural", the Medical Examiner	ed b	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of w during most of working life. DO NOT use retired to the control of t		16b. Kind of Business	
	Completed	Grade 3 Janitorial		Residentia	al Apartment
21215-0036 Mental Hygiene. Mental Hygiene t cvent, the Medica	မ္မ	17. Father's Name (First, Middle, Last) Nathaniel Berry Loubonne		•	
D 21215-003(should be filed within and Mental Hygiene 7 is marked other than natic event, the Medic		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or R		,	e, Zip Code)
e, MD and 2 sho leafth and frem 27 is traumati	ŀ	Andre Muhammad / son 8201 Meadowfield Way 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Laurel Date	, Maryland 20c. Location - City o	20708 r Town, State
Baltimore, MD 2121 permit. Pages 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked injury or other freaumatic event,		1 Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: A. Lincoln Nat. Cem. 10/1	14/2011	Elwood, 1	Illinois
Balti permit. Departn Imports Injury o	Ī	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral	Home,	P.A.	
Physician	+	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or failure. List only one cause on each line.	E Laur respiratory arr	el, Marylar est, shock, or heart	Approximate Interval Between Onset and
/Medical xaminer		Immediate Cause (Final disease or condition resulting in death) a. Acute Cholecystitis Due to (or as a consequence of):			Death
		Sequentially list conditions, b			
	틸	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Uisease or injury that initiated			
uted nd ransit	Exa	events resulting in death) Last Due to (or as a consequence of): d.			
760, icate be executed physician and the burial - transit	Medical	☐ AMENDED 23a,27,per me,g920 10-20-11 sm			
6876 ertificate ding phy	W/ug	F FEMALE: 3b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy	ncy	23d. Date of delive Month	ry Day Year
he death certific	Physician/	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (Specify)		0	
	g F	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		obacco use contribute to	
w requires s been sign should be	eted		24a. Was	an 24b. Were a	utopsy findings available
Pecol	Completed		autor perfo 1 V Yes	rmed? death?	completion of cause of
of Vital Records, og Physician: The law require there this certificate has been si meral director, page 2 should be at The Record the certificate has been si meral director.	B .	25. Was case referred to medical examiner? 1 Vec 2 No	only one)		
ing Phys Ing Phys After this Suneral di	٩	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?		Residence 6 Other	er: Scene
Division al or Attendit as a and the death. al Director: A led in by the fu	Catio	Natural 5 Pending 1 Yes 2 No long 2 Accident Investigation			
Divising the pital or At ours after deal Direct filled in by Cortifical	린	Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (or Town, §		ural Route Number, City
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and constant 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at	due to the caus	se(s) and manner as sta	ted.
To To To Com	Medical	29b. Signature and title of certifier 29c. License number		29d. Date signed (M	
	L	Cercol Hallan O.C.M.E.		October 8, 2011	
		 Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, ME 	21223		
Stat Registra	te ³	11. Date filed (Month, Day, Year) 32. Registrar's Signature	•	3	
DHMH 17 Rev 1/2001		OCME ORIGINAL			

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ BARNETI 12:45 P Medical 2011 **Examiner** 4c. County of Death MONTGOMER **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Country) Director or 28a-f shov Examiner must be notified at 10d. Inside City Limits Director 1 X Yes 2 ☐ No 10g. Citizen of What Country Funeral marked other than "natural", or items 23a Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 1 ☐ Yes : If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 Divorced Year or Dates. the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) NATIONAL Elementary/Secondary (0-12) College (1-4 or 5+) Department of Health and Mental Hygiene. Important: If item 27 Is marked other tha other traumatic event, Be should be filed WINBURN 19a. Informant's Name/Relationship (Type, Print) DAUCHTE/2 Page 1 and 2 20b. Place of Disposition (Name of 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) any injury or Signature of Pune al Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Pnysician/ Medical Onset and Death disease or condition resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury as the burial-tran that initiated events been signed by the attending physician and resulting in death) Last Be Completed by Physician/Medical P.O. Box 68760 IF FEMALE: completely filled in by the funeral director, page 2 should be detached for use If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death g Unknown To the Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy performed? Yes 21 No death? 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Certificate: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work 2 🗌 No Accident Investigation 6 Could not be Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 U Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State

DHMH 17 Rev 06-2011

Registrar